HIV/STD ANNUAL REPORT 2002

Texas Department of Health
Bureau of HIV & STD Prevention

Mario R. Anzaldua, M.D.
Chair, Texas Board of Health

Eduardo J. Sanchez, M.D., M.P.H.
Commissioner of Health

TABLE OF CONTENTS

List of Figures ii

List of Tables ii

Acknowledgements iii

I. Executive Summary 1

II. Bureau of HIV and STD Prevention 2

III. Funding- Fiscal Year 2001 4

IV. Epidemiologic Assessment 5

V. HIV Prevention and Services 18

VI. STD Prevention and Services 27

VII. Training and Public Education 31

VIII. HIV/STD Clinical Resources 33

IX. Appendix 40

List of Figures

1. Organizational Chart _____ 3
2. HIV Prevention and Services Contracts Awarded _____ 4
3. AIDS Cases by Year of Report _____ 6
4. HIV/AIDS Cases by Race/Ethnicity _____ 7
5. Adult-Adolescent AIDS Cases by Mode of Exposure & Sex _____ 9
6. Adult-Adolescent HIV Cases by Mode of Exposure & Sex _____ 9
7. Primary and Secondary Syphilis Cases: Texas, 1988-2001 _____ 10
8. P & S Syphilis Case Rate by Race/Ethnicity, Texas 2001 _____ 11
9. P & S Syphilis Case Rates Among African Americans by Age Group and Sex, Texas 2001 _____ 12
10. Syphilis Case Rates, Texas 1981-2001 _____ 13
11. Chlamydia Cases, Texas 1988-2001_____ 14
12. Chlamydia Case Rates Among Women by Race/Ethnicity, Texas 1991-2001_____ 14
13. Gonorrhea Cases, Texas 1972-2001_____ 15
14. Gonorrhea Case Rates by Race/Ethnicty, Texas 1991-2001 _____ 15
15. Chlamydia and Gonorrhea Cases by Age Group, 2001 _____ 17
16. Texas HIV/STD Planning Areas _____ 18
17. The Disease Intervention Process _____ 28
18. The Texas HIV Medication Program _____ 34

List of Tables

1. TX AIDS Cases Reported by Race/Ethnicity and Sex, 2001 _____ 8
2. TX HIV Cases, 2001 _____ 7
3. Publicly Funded HIV Tests and Positive Tests by Sex and Ethnicity _____ 22
4. HIV Tests and Positive Tests by Sex and Mode of Exposure _____ 23

Acknowledgements

Thank you to the following staff of the Texas Department of Health, Bureau of HIV and STD Prevention for their contribution to this report: Susan Aulds, Joe Flores, Brenda Howell, Sharon King, James Koch, Lori Lagrone, Gary Lawrence, Jim Lee, Ann Robbins, Ray Toburen, Jay Todd, Pat Villegas, Kathie Walden, Sylvia Watson, and Ed Weckerly.

I. EXECUTIVE SUMMARY

From the beginning of the Human Immunodeficiency Virus (HIV) epidemic in the early 1980s to the end of 2001, over 57,199 acquired immunodeficiency syndrome (AIDS) cases have been reported in Texas. A total of 113,923 sexually transmitted disease (STD) cases excluding HIV/AIDS were reported in Texas in 2001. While reported cases of syphilis declined, chlamydia, gonorrhea and pelvic inflammatory disease (PID) increased. Young people aged 15 to 24 years accounted for over 67 percent of all reported STDs, with adolescents aged 15 to 19 accounting for over 34 percent of these cases.

The total operating budget for HIV and STD programs, Bureau of HIV and STD Prevention, Texas Department of Health (TDH), for fiscal year (FY) 2002 was $121,628,776. The Bureau distributed almost $44 million to regional and local health departments and community-based organizations throughout the State in 2002.

HIV prevention efforts focused on the high risk target populations identified through community planning activities. A total of 118,717 initial prevention counseling sessions were reported in 2001; 94 percent of initial counseling sessions included an HIV test, and this testing yielded a positivity rate of 1.2 positives per 100 tests. Over 10,000 HIV positive clients received publicly funded medical support services in FY 2002. Prevention activities provided by STD programs resulted in the location, counseling, and testing of 1,679 HIV sex/needle sharing partners of HIV positive individuals and the identification of 171 new HIV infected persons. Disease Intervention Specialists (DIS) also interviewed and managed 1,363 syphilis cases in Texas in 2001. A total of 455 new cases of syphilis were identified and referred for treatment by DIS.

HIV counselors were trained at locations across Texas; some counselors receiving customized training specific to the individual needs of their programs. The Texas HIV/STD InfoLine, which provides a telephone link between the people of Texas and the TDH, received over 2,561 calls during FY 2002.

The Texas HIV Medication Program worked with 238 participating Texas pharmacies and distributed approximately $62 million dollars of antiretrovirals and other HIV prophylactic medications in FY 2002. The medications help delay the onset of symptomatic disease and prevent opportunistic infections in persons living with HIV disease. The Texas HIV Medication Program also distributed STD medications and supplies to 52 sites statewide in 2002.

*Note: The Annual Report for 2002 is based on the previous fiscal year, September 2001 - August 2002. Due to time constraints in collecting and reporting research and epidemiological data, sections of the report containing this information may be based on the previous calendar year, January 2001 - December 2001.

II. BUREAU OF HIV & STD PREVENTION

The TDH, Bureau of HIV and STD Prevention (Bureau) consists of three Divisions: the HIV/STD Health Resources Division; the Epidemiology Division; and the Clinical Resources Division (**Figure 1**). The HIV/STD Health Resources Division is responsible for policy and planning, field operations, monitoring, training and technical assistance, grants, and contract development. The Epidemiology Division includes surveillance, epidemiologic assessment, research and evaluation, data management and other technical functions. The Clinical Resources Division supports all medication programs across the department including the Texas HIV Medication Program. Additionally, the Clinical Resources Division provides expertise, technical assistance, and policy direction on all clinical issues.

Mission Statement

Our mission is to prevent, treat, and/or control the spread of HIV, STD, and other communicable diseases to protect the health of the citizens of Texas. In keeping with this mission, we procure, allocate, and manage fiscal and human resources so that we may:

- *Provide HIV/STD education and information,*
- *Collect, interpret, and distribute data relating to HIV and STD,*
- *Provide guidance to those who oversee, plan for, or provide HIV and STD services, and*
- *Provide medication and supplies to prevent, manage, and treat communicable diseases.*

In pursuit of this mission, we will make every effort to assure that the citizens of Texas receive quality services.

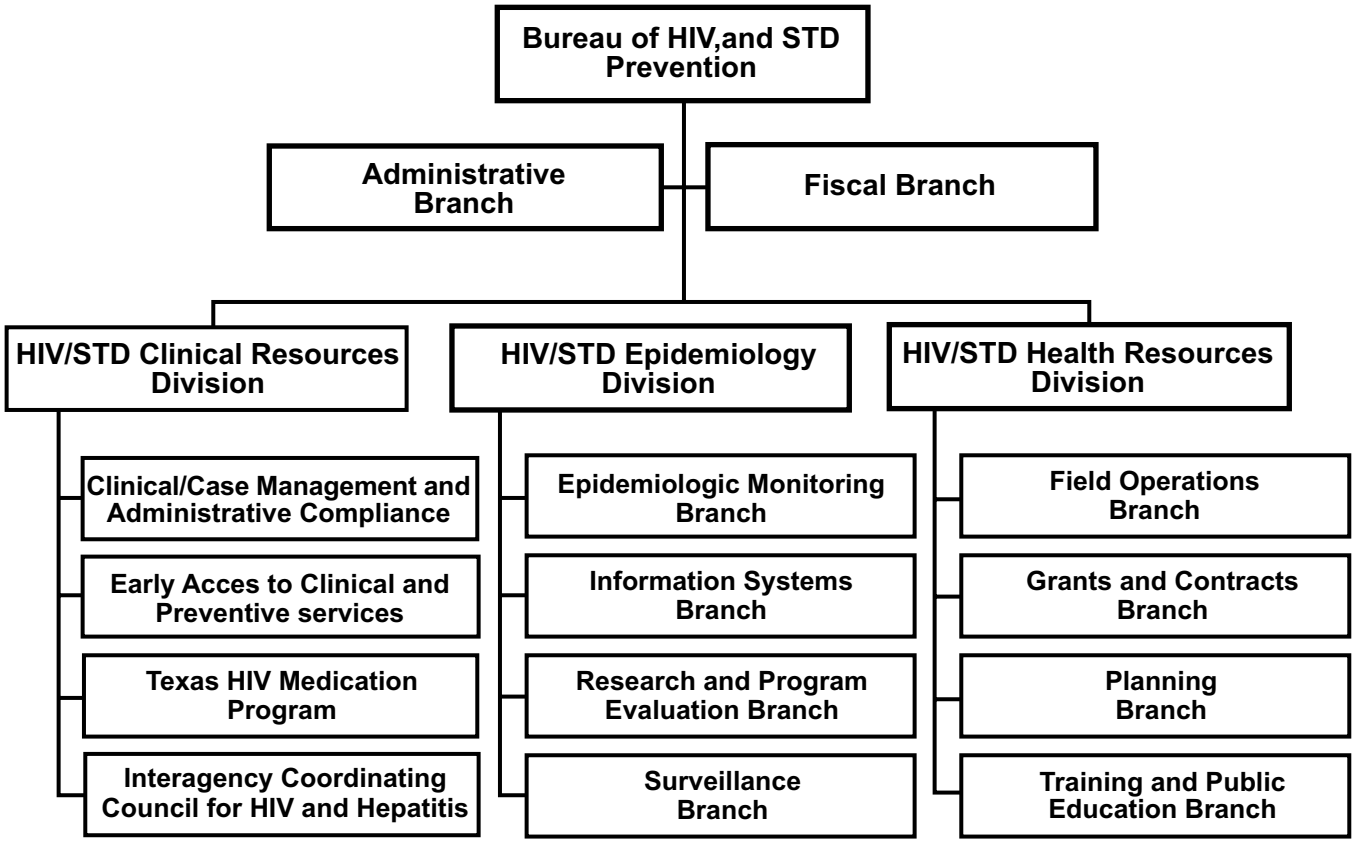
The Bureau is dedicated to preventing the spread of HIV and other STDs and minimizing complications and costs. This is achieved primarily through education, prevention counseling, screening and testing, partner elicitation and notification, and the provision of medical and social services. The TDH provides some of these services directly, but most often through contracts with local agencies to provide community-based services when appropriate. This report documents many of the activities and accomplishments of the Bureau in 2001 and provides an epidemiologic assessment of HIV, AIDS, and STDs in Texas.

Bureau of HIV and STD Prevention Strategic Plan

The Bureau's process to revise the strategic plan began in July 2001 with the formation of a core group of staff members including the Bureau senior managers and central office senior administrative staff. Planning Branch staff facilitated the discussions and documented the results. Before writing the plan, the core group members discussed how the strategic plan would be used and monitored or assessed. The Bureau's vision and mission statements were reviewed and reaffirmed. Other considerations by the group included the development of definitions, philosophy and guiding principles, the role of and impact on regional staff and why most strategic plans fail. Guiding documents were identified and discussed. These included: the Health and Human Services Commission Strategic Plan (1999-2003), the TDH Strategic Plan (2001-2005), the Center for Disease Control and Prevention (CDC) HIV Prevention Strategic Plan (2001-2005), Healthy People 2010, Institutes of Medicine Reports on STD and HIV prevention, Health Resources and Services Administration (HRSA) principles, HRSA Ryan White Reauthorization, CDC's "A Sero-status

Approach to Fighting the HIV/AIDS Epidemic (SAFE) Initiative" and the Bomer Report.[1] The core group developed a list of proposed initiatives, outcomes, and outcome measures. With numerous competing priorities, the challenge remains to finalize the initiatives on which to focus the Bureau's attention and staff efforts. A timeline was developed and agreed upon which proposed a finalized strategic plan document by December 31, 2001. Completion of the process has been delayed, however, due to competing demands for Planning Branch Staff time.

Figure 1 Bureau of HIV and STD Prevention Organizational Chart



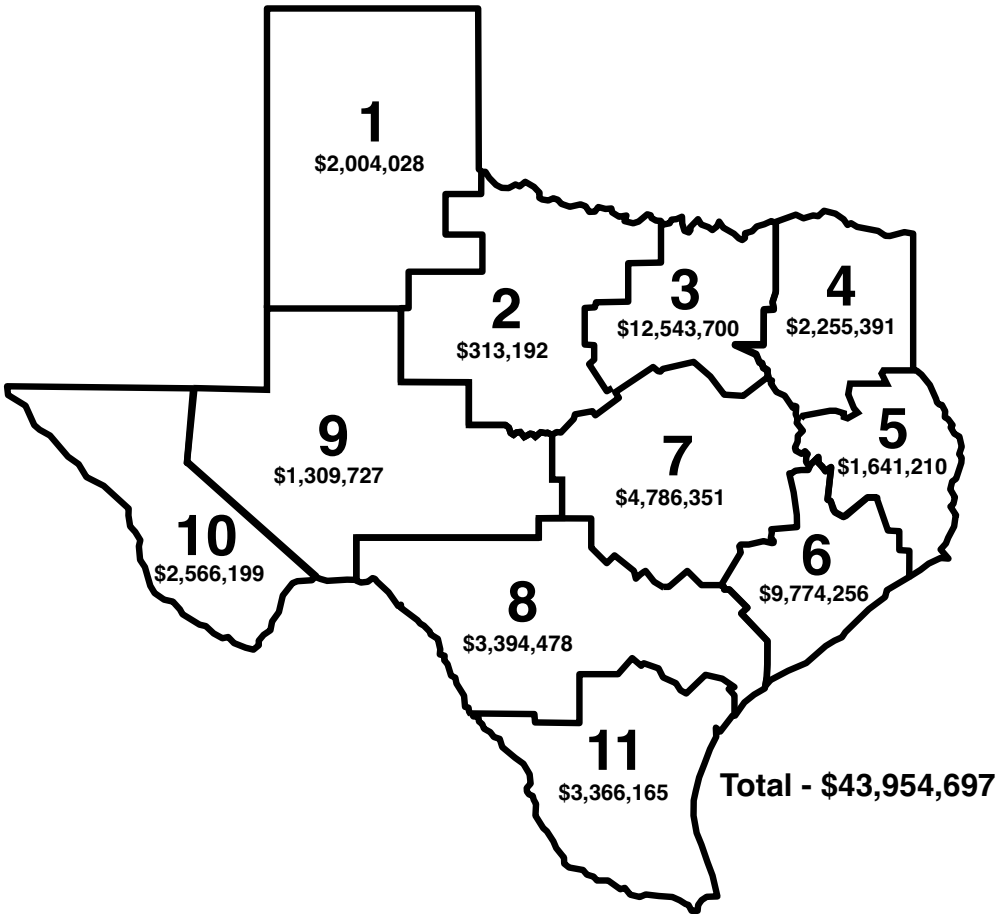
1 Texas Department of Health Business Practices Evaluation, August 31, 2001.

III. FUNDING – FISCAL YEAR 2002

The total operating budget for HIV and STD programs for FY 2002 was $121,628,776. Over three-quarters of the budget, $93,034,334, was provided by federal HIV and STD grants, and the remainder, $28,594,442 by State funds. The HIV and STD funds were allocated as follows: $27,083,144 (22%) for prevention; $33,175,912 (27%) for services; $56,213,356 (46%) for medication; and $5,156,363 (4%) for surveillance. The 2002 budget represented a 7% increase over the 2001 budget, most of the increase being allocated to the medication program as clients are staying on the program longer due to the success rate of new drugs.

Almost $44 million, more than 36% of the total HIV and STD prevention and services resources were distributed to regional and local health department and other contracted community-based agencies through prevention and service contracts (**See Figure 2**). Approximately 45% of the total HIV and STD resources were spent providing HIV and STD medications throughout Texas. Other Bureau expenditures included training and public education, regional and cental office administrative costs, laboratory costs, travel to support training, technical assistance, and monitoring, supplies and equipment, and public health promotion. Administration encompasses activities such as program planning and development, program evaluation, quality control and technical assistance to contractors, contract monitoring, grants management, and support services. The Bureau also spports the Funding Information Center (FIC) with HIV funds. The FIC researches and disseminates HIV/AIDS-related funding information to the Texas public.

Figure 2. HIV Prevention and Services Contracts Awarded by PHR
2002 State and Federal Funds



IV. EPIDEMIOLOGIC ASSESSMENT

HIV/AIDS

AIDS is the late stage of infection with HIV and is characterized by severe immunosuppression and co-infection with other opportunistic agents. HIV specifically infects and depletes a subgroup of white blood cells (lymphocytes) called helper T-lymphocytes. These cells are also called CD4+T-cells, which is a term based on laboratory tests that identify these cells by the presence of a specific cell surface marker, CD4. The decline in the number of CD4+T-cells is an indicator of HIV disease progression.

The CD4+ T-cell count became an important part of the AIDS surveillance case definition that the CDC revised in 1993. The new case definition of AIDS includes all HIV-infected persons with CD4+ T-cell counts fewer than 200 per microliter of blood, or less than 14% of total lymphocytes. Before this change, the case definition relied on a confirmed positive HIV test and the identification of one of several indicator diseases that commonly occur among immuno-compromised HIV-infected patients.

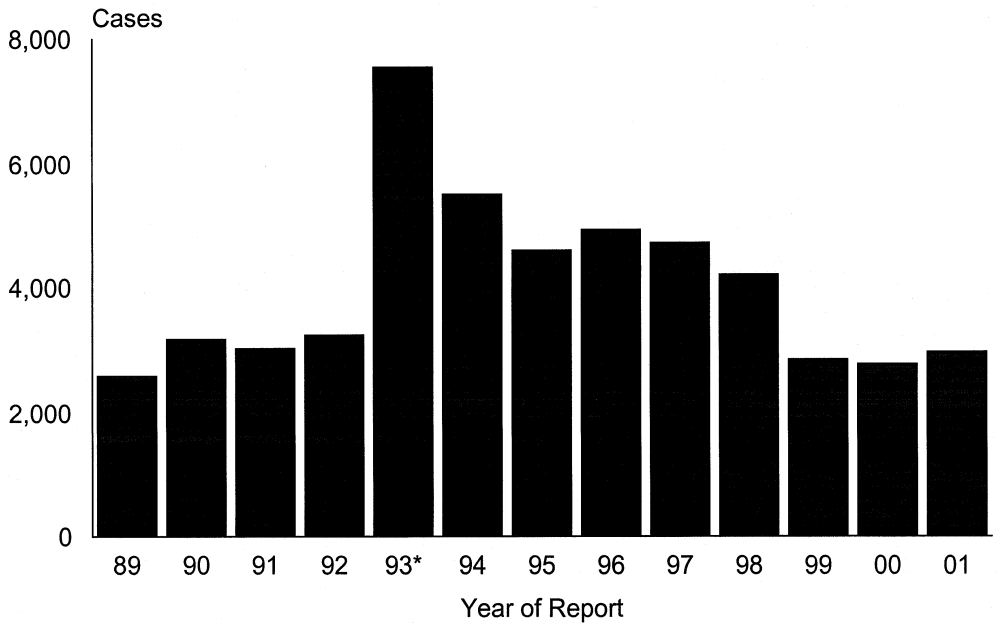
Viral load tests have been developed that quantify the level of HIV virus circulating in the bloodstream, and are used in conjunction with CD4+ T-lymphocyte counts to determine status of disease. Viral load tests are a sensitive measure of the HIV nucleic acid in the peripheral blood and other body systems. Viral load testing is used to evaluate newly diagnosed disease, to monitor disease status, to establish a baseline value prior to antiretroviral treatment, and to monitor health status during treatment. In January 2000, the Texas Department of Health began mandatory HIV viral load reporting. This occurred because the surveillance case definition for HIV was updated by the CDC in December of 1999, to include a detectable viral load as an independent criterion for HIV.

To develop effective prevention strategies, prompt identification and reporting of new infections is essential. The quality of Texas HIV surveillance was improved when reporting rules were revised to require reporting of HIV infections by name beginning in 1999. These data capture only those cases with a reported HIV testing date on or after January 1, 1999, not previous positives for HIV. Nor do these HIV data include anonymous tests, unless the individual was subsequently tested by name.

2001 Texas AIDS/HIV Statistics

By the end of December 2001, 57,199 persons with AIDS had been reported in Texas since the start of the epidemic in the early 1980s. Texas ranked fourth highest in the US, with 2,981 AIDS cases reported in 2001. The overall AIDS rate for Texas was 14.4 AIDS cases per 100,000 population, up from 13.7 in 2000 **(Table 1)**. Although AIDS case numbers had been falling in the late 1990s and 2000, a slight increase (6%) in AIDS cases were reported in 2001. In addition, 4,241 HIV, not AIDS, cases were reported in 2001 **(Figure 3)**. This number is down slightly from cases reported in 2000 (a 4% decrease), however, since Texas HIV data collection and named reporting was initiated in January, 1999, it is difficult to interpret trend data at this time.

Figure 3. AIDS Cases by Year of Report, 1989-2001



57,199 Cumulative Cases Reported Through 12/31/01.
*Expanded AIDS surveillance definition implemented.

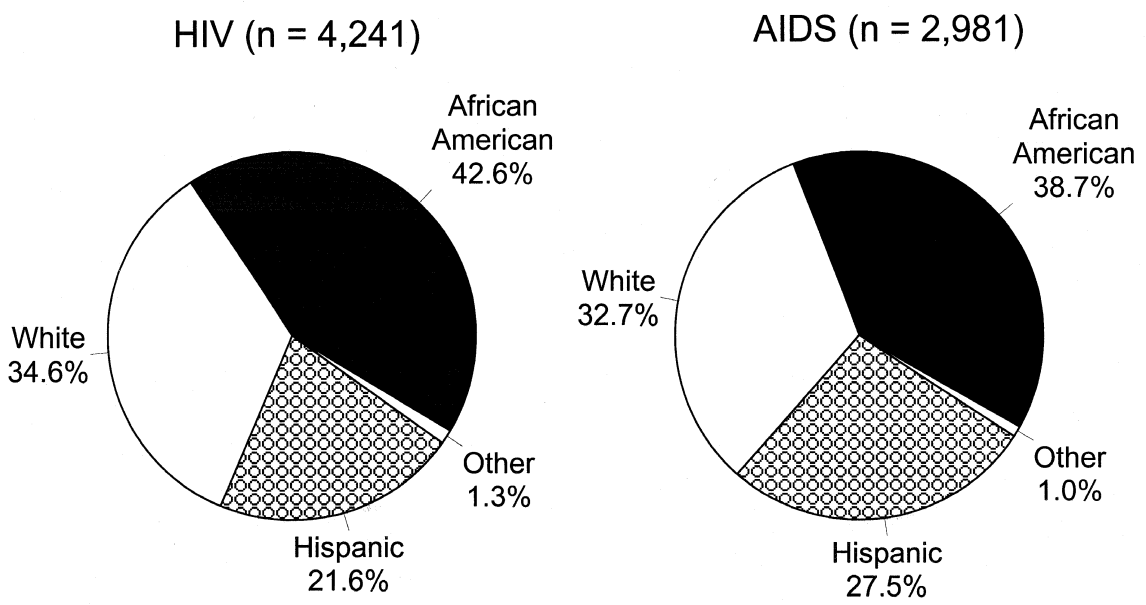
Rates by Sex and Race/Ethnicity

For Texas males, the 2001 AIDS rate, (22.8/100,000), remained much higher than the female AIDS rate (6.2/100,000). The Texas male HIV rate for 2001 was 30.1 cases per 100,000 population, while the female HIV rate of 11.1 cases per 100,000 population demonstrated the increasing rate of new infections among women **(Table 2)**.

The highest percentage of year 2001 AIDS cases was reported among African Americans (39%), followed by the Whites (33%), and Hispanics (27%) (Figure 4). The rate of reported AIDS cases in 2001 among Texas' African Americans (49.2/100,000) was four to five times higher than the rates for Hispanics (12.6/100,000) or Whites (8.7/100,000, Table 1). The African American female rate (32.3 cases per 100,000) was more than five times higher than the Hispanic and the White female rates (4.0 and 2.0 cases per 100,000, respectively). The Texas African American male population had the highest AIDS case rate at 67.5 cases per 100,000, followed by Hispanic males at 20.9 cases per 100,000 and White males at 15.8 cases per 100,000.

As **Figure 4** illustrates, the highest proportion of HIV cases were among African Americans (43%), followed by Whites (35%) and Hispanics (21%). The rate of reported HIV cases in 2001 among African Americans in Texas (77.0/100,000) was more than five times higher than the rates for Whites (13.1/100,000) or Hispanics (14.0/100,000). The African American female rate was significantly higher at 57.8 cases per 100,000 than the Hispanic and the White female rates (6.3 and 4.3 cases per 100,000, respectively). Among Texas males, the African American male population had the highest HIV rate at 97.7 cases per 100,000, followed by White males at 22.3 cases per 100,000 and Hispanic males at 21.5 cases per 100,000.

Figure 4. HIV & AIDS Cases by Race/Ethnicity 2001



Modes of Exposure

Lower than last year, the men who have sex with men (M/MS) exposure category constituted slightly less than half (48%) of the 2001 AIDS cases among Texas men **(Figure 5)**. Additionally, injecting drug use (IDU) was the most likely route of transmission for 12% of men reported with AIDS. The combination of MSM and IDU constituted 7% of the cases among males, and the heterosexual route of transmission was reported for 7% of men with AIDS. Among women, the exposure category "heterosexual contact" accounted for 40% and the use of injecting drugs was designated as the mode of exposure for 20%. A higher percentage of cases among women (39%) than men (25%) were initially unclassified as to mode of exposure. For both sexes, the percentage of cases that remain unclassified will decrease as the investigations of risk are completed. However, due to the definition of "Heterosexual Contact" used by the CDC, many heterosexually acquired infections remain categorized as "Not Classified". Only those individuals whose risk for HIV infection is heterosexual sex with a known HIV infected partner are classified as "Heterosexually Acquired". Those individuals whose risk is heterosexual sex with multiple partners whose HIV status is unknown remain "Not Classified". The only increases in proportion of AIDS cases due to a certain mode of exposure for year 2000 to 2001, was among the heterosexual mode, for both males and females.

For HIV infections reported in 2001, the MSM exposure category constituted half (50%) of HIV cases among Texas men **(Figure 6)**. Additionally, injecting drug use was the most likely route of transmission for approximately 13% of men reported with HIV. The combination of male-to-male sex and IDU constituted 7% of the HIV cases among males, and the heterosexual route of transmission was reported for 5% of men with HIV. Among women, the exposure category "heterosexual contact" accounted for 36% and the use of injecting drugs was designated as the mode of exposure for 21%. As with AIDS cases, a higher percentage of HIV cases among women (42%) than men (25%) were initially unclassified as to mode of exposure. The proportion of HIV cases acquired through IDU and heterosexual modes of transmission increased from 2000 to 2001. Many of the unclassified cases likely represent heterosexually acquired cases.

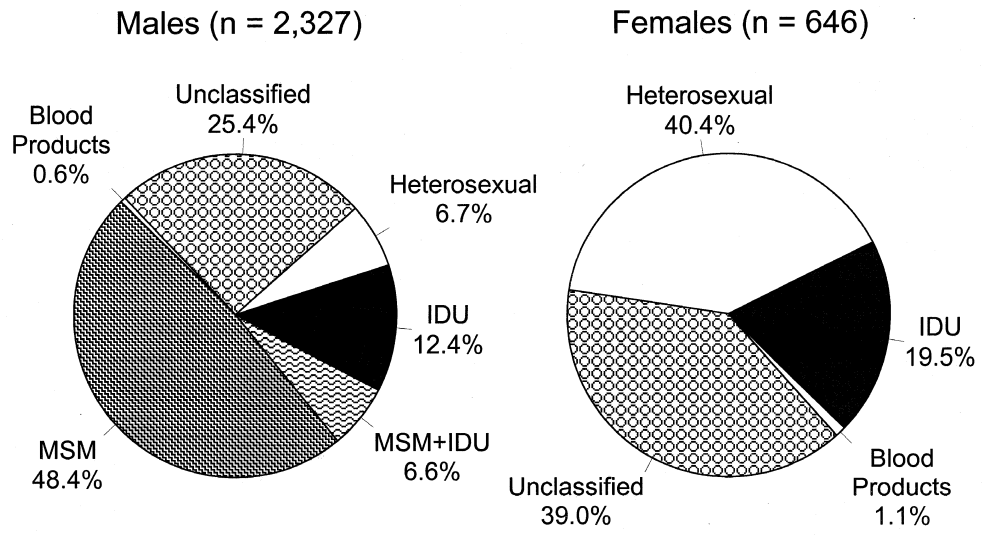
Table 1. Texas AIDS Cases Reported by Race/Ethnicity and Sex, 2001

	Cases	%	Rates (cases per 100,000 population)
Males	2,334		22.8
White	860	37	15.8
African American	761	33	67.5
Hispanic	692	30	20.9
All Others	21	<1	—
Females	647		6.2
White	116	18	2.0
African American	394	61	32.3
Hispanic	129	20	4.0
All Others	8	1	—
Total	2,981		14.4

Table 2. Texas HIV Cases Reported by Race/ethnicity and Sex, 2001

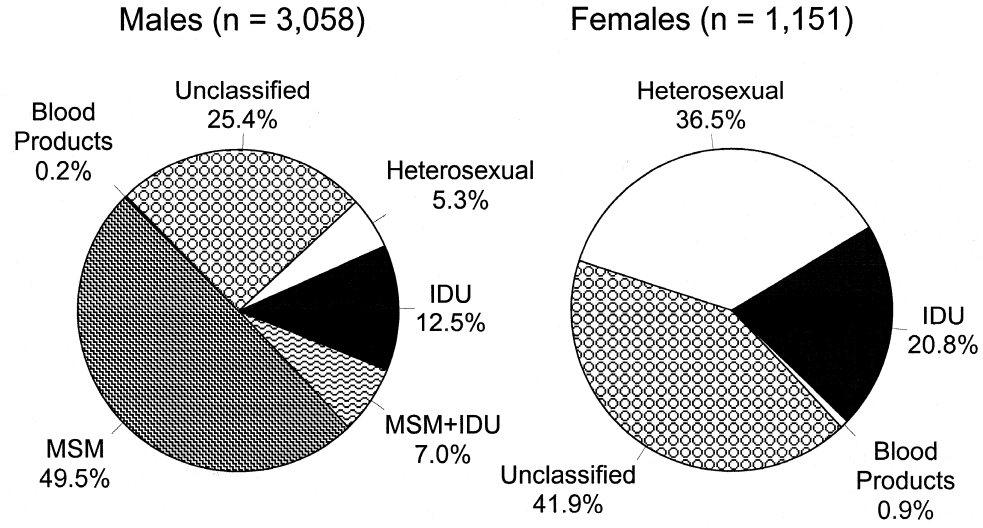
	Cases	%	Rates (cases per 100,000 population)
Males 3,078			30.1
White	1,218	40	22.3
African American	1,102	36	97.7
Hispanic	712	23	21.5
All Others	46	1	—
Females	1,163		11.1
White	248	21	4.3
African American	705	61	57.8
Hispanic	202	17	6.3
All Others	8	<1	—
Total	4241		20.5

Figure 5. Adult-Adolescent AIDS Cases by Mode of Exposure and Sex



*Age 13 or older at time of diagnosis.

Figure 6. Adult-Adolescent HIV Cases by Mode of Exposure and Sex



*Age 13 or older at time of diagnosis.

Geographic Distribution

Most AIDS cases in Texas continue to be reported from metropolitan areas. The largest number of cases reported in 2001 were from Harris County (747), followed by Dallas (720), Travis (204), Bexar (202), Tarrant County (131), and El Paso (121) counties. Dallas County demonstrated the highest rate (32.1), followed by Travis County (Austin) at 30.9/100,000. The Harris County rate was lower at 22.1/100,000 population, followed by El Paso County (15.2), Bexar (14.5), and Tarrant at 8.3 cases per 100,000 population. The Texas Department of Criminal Justice (TDCJ) reported 4.2% of all 2001 AIDS cases. In 2001, 140 counties, (out of the 254 in Texas), reported at least one AIDS case.

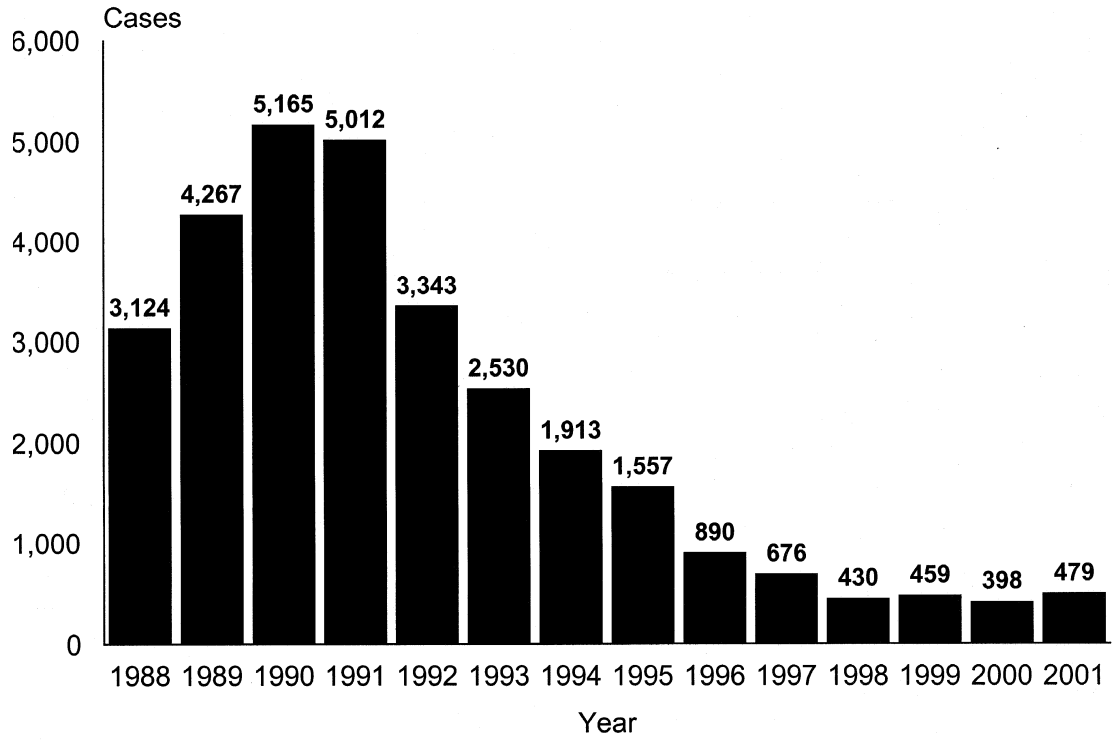
Reports of HIV cases in Texas are also predominantly from metropolitan areas. The largest number of cases reported in 2001 were from Harris County (1215), followed by Dallas (1030), Travis (249), Bexar (211), Tarrant (194), and El Paso (90) counties. Dallas County demonstrated the highest HIV rate, (45.9/100,000), followed by Travis (37.7), Harris (36.0), and Bexar (15.1) counties. The TDCJ reported 6.9% of all 2001 HIV cases. In 2001, 141 counties,(out of the 254 in Texas), reported at least one new HIV case. Although still centered mainly in the metropolitan areas of the state, the HIV epidemic continues to spread to more rural areas, requiring prevention education, health care, and services in all counties.

Sexually Transmitted Diseases

Primary and Secondary Syphilis

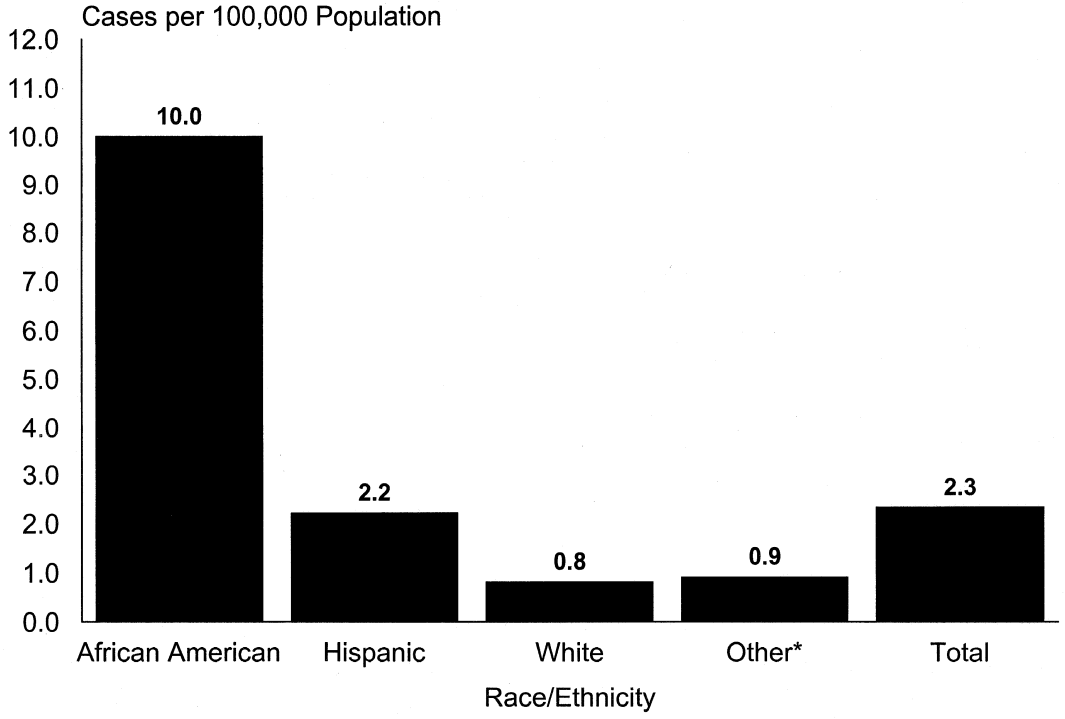
The spirochete *Treponema pallidum* causes syphilis. Primary and secondary (P&S) syphilis, the acute form of the disease, is characterized by primary lesions (an ulcer or chancre at the site of infection), followed by secondary infection (manifestations that include rash, mucocutaneous lesions, and adenopathy). Untreated P&S syphilis progresses into a chronic disease with long periods of latency. Statewide, 479 cases of P&S syphilis were reported in 2001. This represented a 20% increase from cases reported in 2000 and ends the downward trend for syphilis in Texas over the previous nine years **(Figure 7)**. In 2001, Texas experienced sustained increases in P&S cases in several counties including Dallas, Harris, Tarrant, Potter, Travis, and El Paso. Bexar and Wichita Counties reported an increased number of cases beginning in 2000, which remained elevated in 2001. Sustained increases in syphilis in these areas have typically centered around either M/MS, prostitutes, or crack cocaine users. Four major metropolitan counties, Dallas, Harris, Tarrant and Bexar, accounted for nearly 70% of all P&S syphilis cases reported in 2001.

Figure 7. Primary and Secondary Syphilis Cases: Texas, 1988-2001



The overall state rate in 2001 for P&S syphilis was 2.3 cases per 100,000 population. Men accounted for 64% of reported cases, a proportion similar to what has been seen in recent years. The age distribution of P&S syphilis cases was fairly even across the three age groups of most common occurrence; 15 to 24 (27%), 25 to 34 (29%), and 35 to 44 (26%) years of age. African Americans continued to account for the largest proportion (49%) of P&S syphilis cases reported in Texas in 2001: the rate of P&S syphilis among African Americans was 10.0 cases per 100,000 population. Although less than one-fifth the 1995 rate of 53.2, the rate for African Americans remained extremely high compared with rates for Hispanics (2.2 cases per 100,000 population) and Whites (0.8 cases per 100,000) **(Figure 8)**. Among African American women, those aged 20 to 24 had the highest rate at 21.1 cases per 100,000 population. The highest rate for African American men was found among a slightly older age group, those aged 30 to 34, at 23.9 cases per 100,000 **(Figure 9)**. The extremely high case rate for both sexes indicates that P&S syphilis continues to be a significant problem among African Americans in Texas.

Figure 8. Primary and Secondary Syphilis Case Rates by Race/Ethnicity, Texas 2001

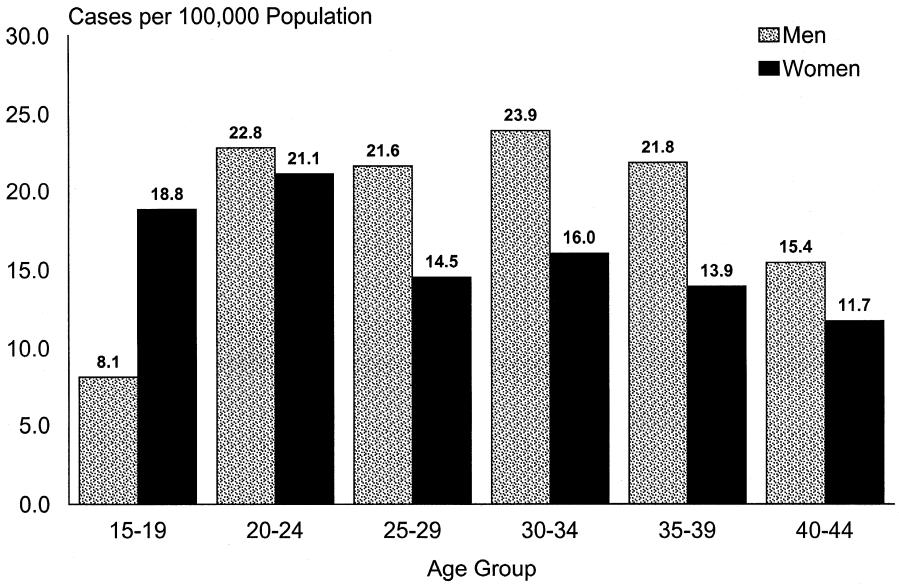


* Excludes cases of unspecified race/ethnicity

Early Latent Syphilis

Latent syphilis is defined as those periods after infection with *Treponema pallidum* when patients demonstrate no evidence of disease. Patients who have latent syphilis and who acquired syphilis within the preceding year are classified as having early latent syphilis; untreated cases of more than one year's duration are classified as late latent. A number of cases each year also are classified as latent syphilis of unknown duration. Tertiary syphilis is symptomatic late-stage disease that may include neurologic and cardiovascular sequelae. The late latent and tertiary stages of syphilis are not discussed separately in this article because those individuals contracted the disease many years prior to their cases being diagnosed and reported, and syphilis is not as likely to be transmitted in these late stages. Thus, there are limited public health implications to these diagnoses.

Figure 9. Primary and Secondary Syphilis Rates Among African Americans by Age Group and Sex, Texas 2001



Like P&S syphilis, early latent syphilis case rates have generally declined in the past ten years, however while drops in P&S syphilis have leveled out recently, early latent syphilis continues to decrease **(Figure 10)**. The total number of early latent syphilis cases in 2001 was 972, down from 1,175 in 2000 but still nearly twice the number of P&S syphilis cases. The overall rate of early latent syphilis in 2001 was 4.7 cases per 100,000 population. The incidence rate for early latent syphilis among African Americans was 21.0 cases per 100,000, compared to 5.1 among Hispanics and 1.2 among Whites.

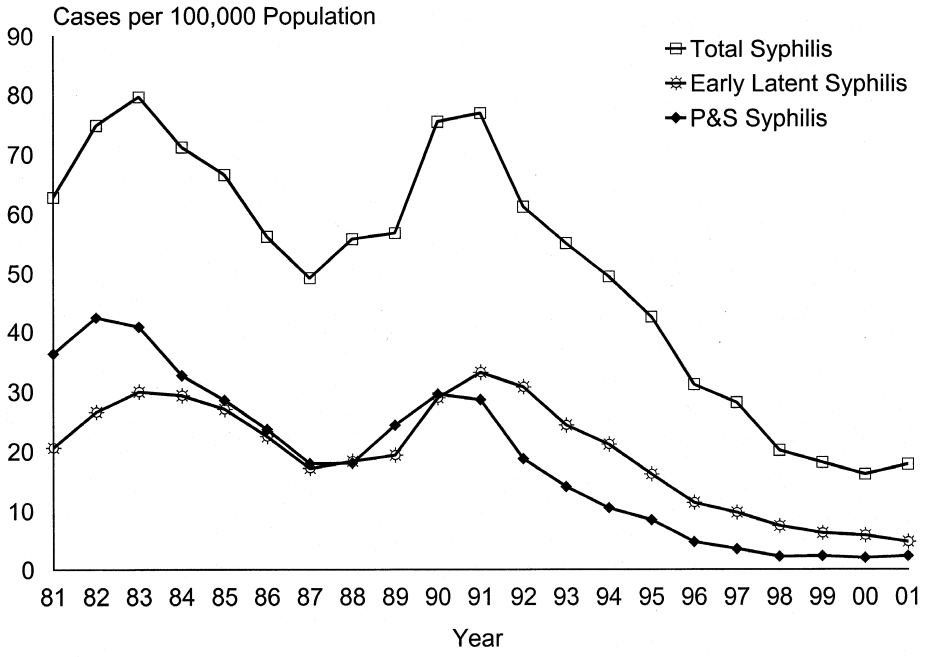
Congenital Syphilis

Congenital syphilis, one of the most serious forms of the disease, can cause abortion, stillbirth, or premature delivery, or may lead to other severe complications in the newborn. In 2001, 72 cases of congenital syphilis were reported, leveling off after eight straight years of decline. Harris County had the highest number of congenital cases with 20, down from 29 cases reported in 2000. The highest county totals were seen in Bexar and Tarrant Counties with 8 cases each and Dallas County with seven. No other county ha more than 3 cases reported. Statewide, 53% of congenital cases were among Hispanics, 35% among African Americans, and 7% among Whites. Based on 2000 live birth numbers (2001 birth data was unavailable), the estimated rate of congenital syphilis in 2001 was 20 20 cases per 100,000 live births, unchanged from the rate in 2000.

Total Syphilis

The term 'total syphilis' refers to all reported syphilis cases regardless of the stage of the disease. Included in this total are congenital, P&S, early latent, late latent, latent of unknown duration, and tertiary syphilis. In 2001, 3,700 cases of total syphilis were reported, for a statewide rate of 17.9 cases per 100,000 population. This ended the nine straight years of decline in total syphilis numbers and is the result of the sustained increases seen in several Texas counties in 2001 **(Figure 10)**.

Figure 10. Syphilis Case Rates, Texas 1981-2001



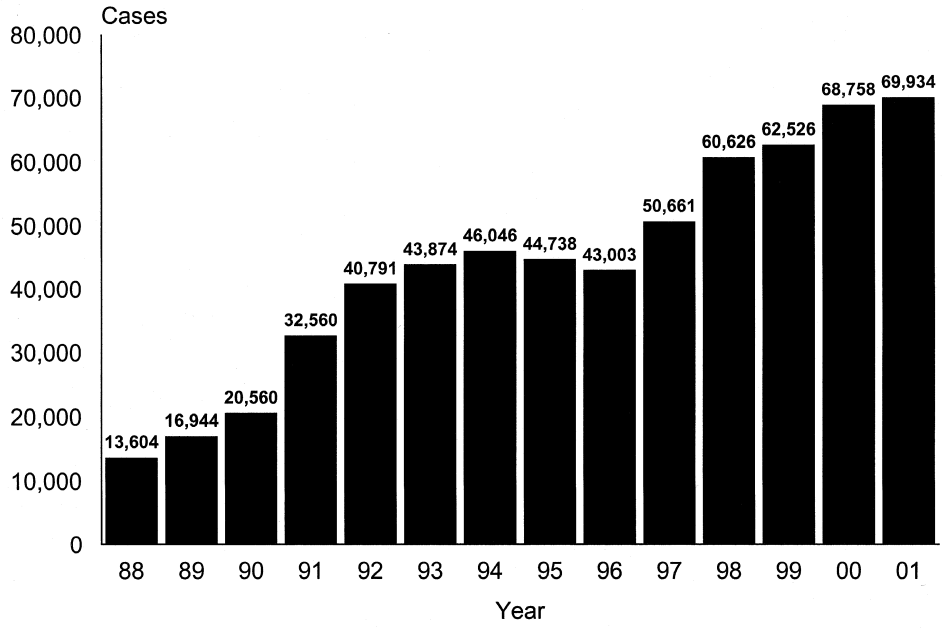
Chlamydia

The microorganism *Chlamydia trachomatis* is one of the most common causes of sexually transmitted infections. Reports of chlamydia in 2001 totaled 69,934, a 2% increase from 68,758 cases in 2000 **(Figure 11)**. Of the total chlamydia cases reported, 83% were among women. Women are more likely to be screened for chlamydia during clinical exams for family planning, prenatal care, and routine Pap smear testing. Because of the increased risk of severe outcomes, including the potential for pelvic inflammatory disease, ectopic pregnancy, and the possibility of infecting a newborn child, chlamydia screening programs almost always focus on women. Therefore, men are less likely to be tested and diagnosed. Given that men make up a smaller proportion of chlamydia cases reported (17%), the true incidence of chlamydia in the Texas population can not be estimated. Because this infection is frequently asymptomatic among both men and women, chlamydia case reports are largely dependant upon the volume of screenings being conducted, more so than gonorrhea, for example.

Because women accounted for the vast majority of chlamydia reports, rates for each sex should be examined separately. The 2001 case rate for women was 552 cases per 100,000 population with African American women having the highest rate (1,165 cases per 100,000), followed by Hispanic and White women (683 and 159 cases per 100,000 population, respectively) **(Figure 12)**. Men showed a similar racial/ethnic distribution to women, but with far lower rates. Over 74% of all reported chlamydia patients (over 52,000 cases) were 15 to 24 years of age. The rates for chlamydia among women aged 15 to 19 and 20 to 24 were 3,073 cases and 2,826 cases per 100,000 population, respectively.

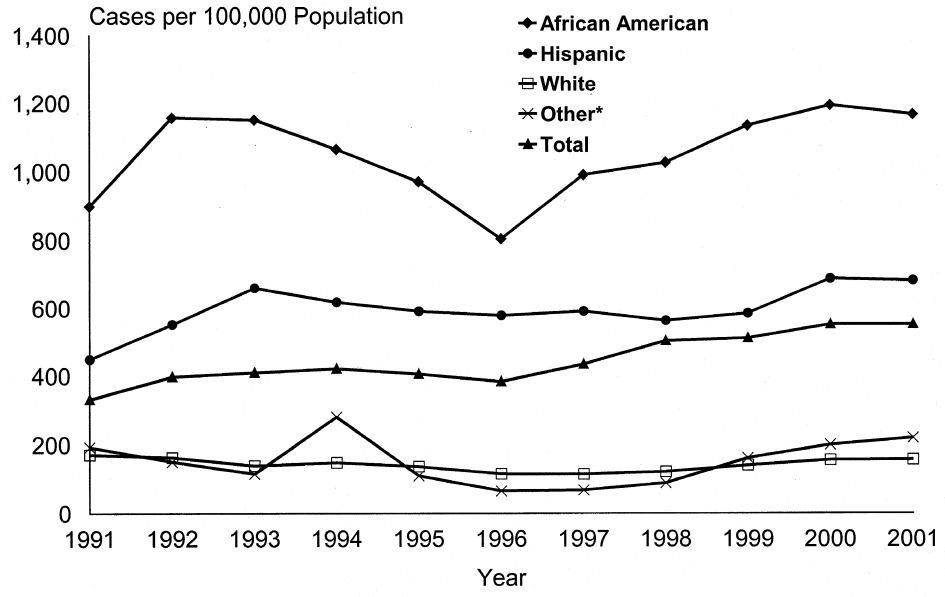
Statewide the total number of clients screened for chlamydia through public funding increased less than 1% from 294,706 in 2000 to 296,142 in 2001; the number of positives resulting from these screenings increased less than 1% from 21,222 in 2000 to 21,417 in 2001.

Figure 11. Chlamydia Cases, Texas 1988-2001



* Chlamydia reporting in Texas began in 1987

Figure 12. Chlamydia Cases Rates Among Women by Race/Ethnicity, Texas 1991-2001



* Excludes cases of unspecified race/ethnicity

Gonorrhea

The bacteria *Neisseria gonorrhoeae* causes gonorrhea. Left untreated, gonorrhea may lead to sterility in men and pelvic inflammatory disease, ectopic pregnancy, and sterility in women. The 30,116 cases of gonorrhea reported in 2001 represent almost an 8% decrease from the number of cases reported in 2000. Gonorrhea levels in Texas have remained fairly consistent at around 30,000 cases per year for the past four years **(Figure 13)**. The Texas rate for gonorrhea was 145 cases per 100,000 population in 2001, down slightly from the rate in 2000 **(Figure 14).** The rate among women in 2001 (149 cases per 100,000) was only slightly higher than the rate for men (141 cases per 100,000).

Figure 13. Gonorrhea Cases, Texas 1972-2001

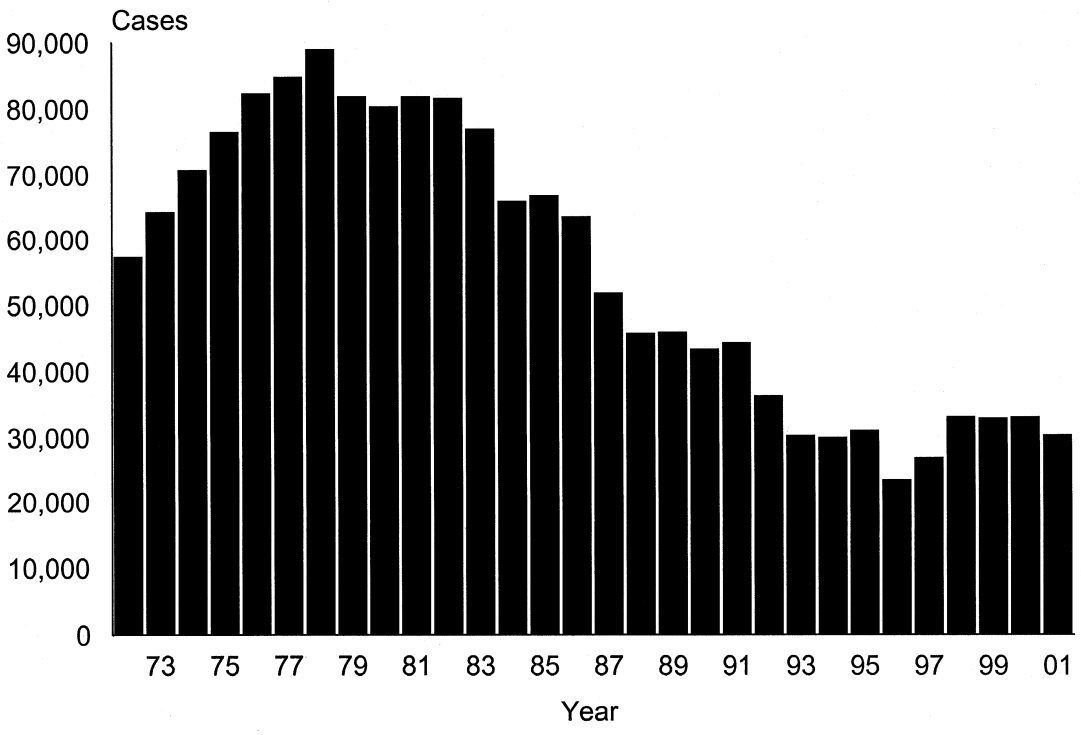
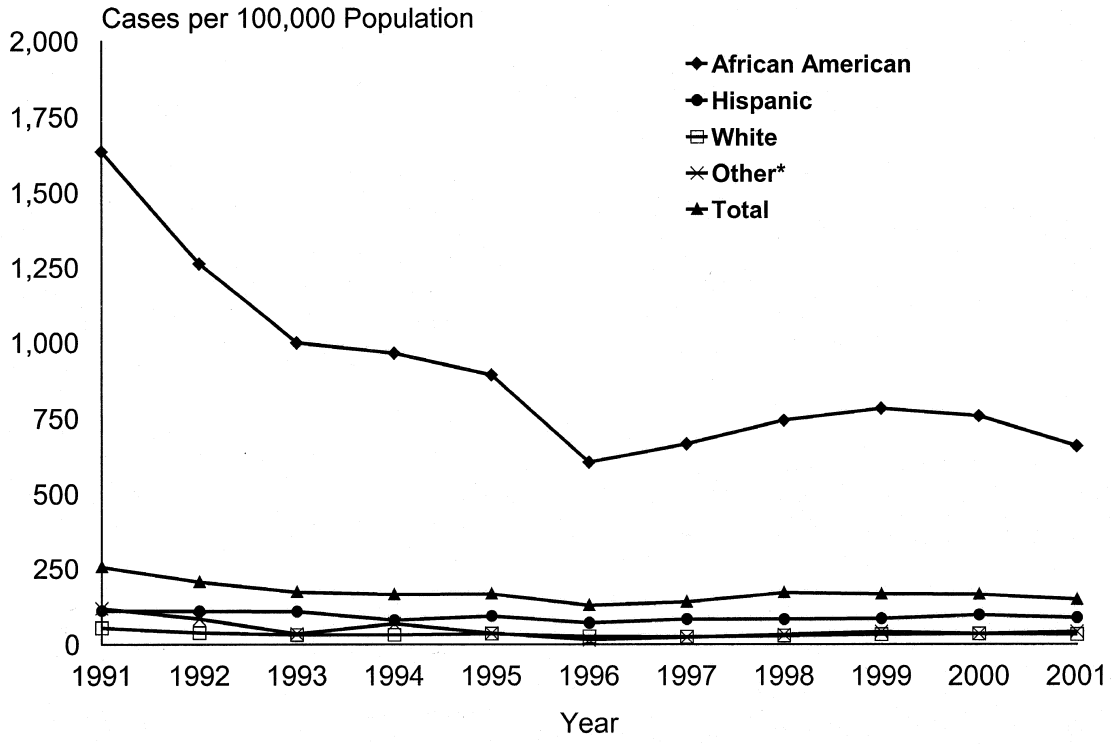


Figure 14. Gonorrhea Case Rates by Race/Ethnicity, Texas 1991-2001



* Excludes cases of unspecified race/ethnicity

The gonorrhea rate for African Americans (659 cases per 100,0000 was over seven times higher than the rate for Hispanics (86 cases per 100,000) and over 20 times higher than the rate for Whites (32 cases per 100,000) **(Figure 14)**. African American men had the highest rate of all race/ethnicity-sex groups at 718 cases per 100,000 population. Gonorrhea cases among African Americans aged 15 to 24 accounted for the greatest share of African American cases (65% of those reported); they also represented 33% of all cases reported regardless of race/ethnicity or age.

Among age groups, the highest rate for women was found in those aged 15 to 19 (816 cases per 100,000) followed by those aged 20 to 24 (715 cases per 100,000). Men in these age groups also had higher rates; 378 cases per 100,000 for the 15 to 19 age group, 581 per 100,000 for those 20 to 24, and 320 per 100,000 for those 25 to 29. Gonorrhea among young women aged 15 to 24 comprised 73% of all cases in women; young men in this age group accounted for 52% of all gonorrhea cases among men.

Statewide the total number of publicly -funded screenings decreased 1% from 295,969 in 2000 to 291,981 in 2001; at the same time the number of positive results from these tests decreased 14% from 13,066 in 2000 to 11,197.

Pelvic Inflammatory Disease (PID)

PID is a serious, sometimes life-theatening complication of untreated chlamydia and gonorrhea in women. Acute PID caused by chlamydia and gonorrhea increases a woman's risk of recurrent PID, chronic pelvic pain, ectopic pregnancy and infertility. In 2001, 1,771 cases attributed to chlamydia or gonorrhea accounted for 43% of the cases rose from 675 in 2001, 36% were cases of unknown etiology. Chlamydial PID case reports rose from 675 in 2000 to 753 in 2001, while gonococcal PID resembles that of other STDs with African American women accounting for 38% of all cases, Hispanic women for 38% and White women for 21%. Young women aged 15 to 24 accounted for 63% of all PID cases in 2001.

Sexually Transmitted Diseases Among Adolescents

Compared to older adults, adolescents (10 to 19 year-olds) and young adults (20 to 24 year-olds) are at significantly higher risk for acquiring STDs for a number of reasons: they may be more likely to have multiple (sequential or concurrent) sexual partners rather than a single, long-term relationship; they may be more likely to engage in unprotected intercourse; and they may select partners who are at higher risk. In addition, for some STDs such as Chlamydia trachomatis, adolescent women may have a physiologically increased susceptibility to infection due to increased cervical vulnerability. During the past two decades, the age of initiation of sexual activity has steadily decreased and age at first marriage has increased, resulting in increases in premarital sexual experience among adolescent women and in an enlarging pool of young women at risk.

The total burden of STDs is estimated at 15 million new infections annually in the United States. Studies indicate that people are two to five times more likely to become infected with HIV when other STDs are also present because theopen lesions associated with STD infections allow portals of entry for the HIV virus. Generally, about one quarter of all STD infections in the US occur among teens. Prevalence studies in various clinic populations and large-scale screening projects have consistently demonstrated that younger women have higher postivity rates of chlamydia than othe women.

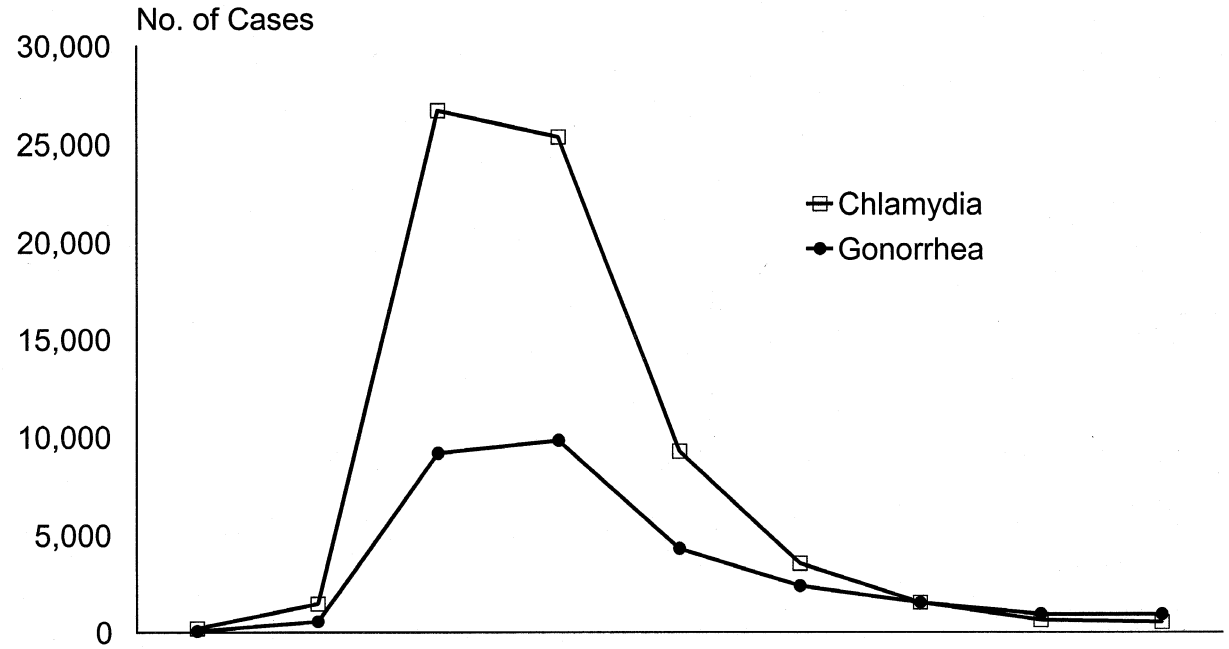
Of the 113,923 cases of STDs reported in Texas in 2001, excluding HIV/AIDS, 67% were among those 15 to 24 years old (see Figure 15) Minority youth make up a disproportionate share of these STD cases. Among 2001 STD case reports that included ethnicity information for those aged 15 to 19, 35% were African American, 31% were Hispanic, and were 15% White. The STD case rate for African Americans

aged 15 to 19 was more than eight times higher than the rate among Whites, and the rate for Hispanic adolescents was more than twice the rate among Whites.

Gonorrhea cases reported in 2001 among those aged 15 to 19 numbered 9,190 and accounted for 31% of all gonorrhea cases. The case rate for this age group was 2,272 cases per 100,000 population for African Americans, 285 per 100,000 for Hispanics, and 126 per 100,000 for Whites. Chmlamydia cases reported in 2001 numbered 26,688 for this age group and accounted for over 38% of all cases reported. The chlamydia case rates for those aged 15 to 19 were 3,561 cases per 100,000 population among African Americans, 1,481 per 100,000 for Hispanics, and 578 per 100,000 for Whites. The true incidence of chlamydia may be much higher because it is usually asymptomatic and detected only by the screening of those seeking medical care for other reasons.

Although young people have a greater risk of being infected with an STD other than HIV, these "traditional" STDs receive less attention than HIV. Prevention methods for both HIV and STDs overlap, but teaching adolescents to recognize the symptoms of traditional STDs and to seek treatment early may prevent more severe forms of the diseases from developing. Educational programs and preventive messages need to be developed and delivered by parents, teachers, religious leaders, youth leaders, professionals working with adolescents, peers, media, and role models. Young people themselves, serving as peer educators, should be enlisted and relied upon as an important part of all STD prevention efforts.

Figure 15. Chlamydia and Gonorrhea Cases by Age Group, Texas - 2001



	0-09	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45+
Chlamydia	212	1,484	26,688	25,366	9,299	3,593	1,561	643	538
Gonorrhea	70	569	9,190	9,846	4,353	2,427	1,543	953	943

V. HIV PREVENTION AND SERVICES

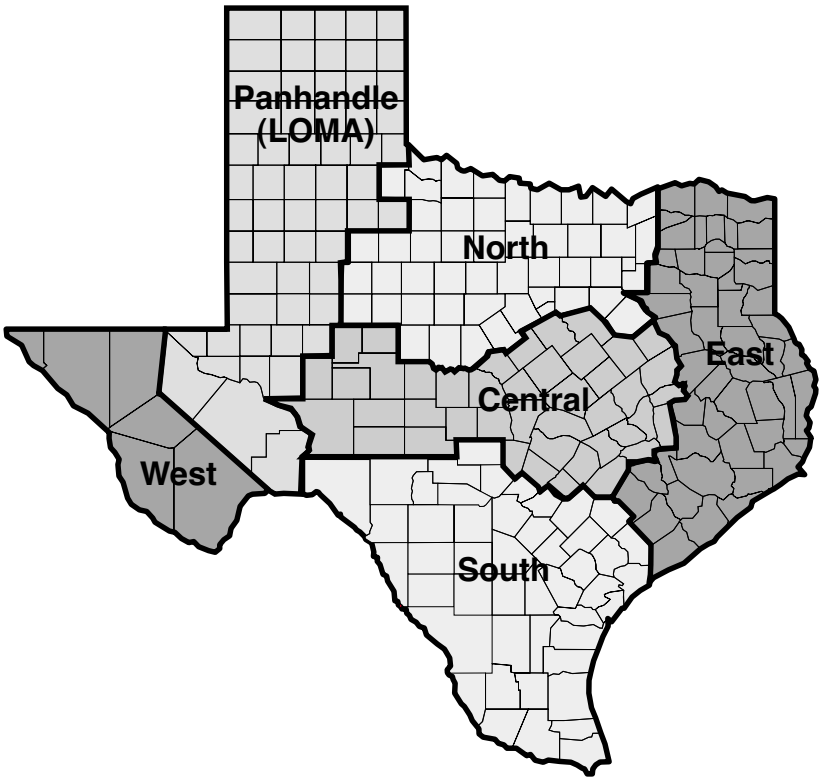
The three components of the HIV Prevention program are Health Education and Risk Reduction (HERR), Prevention Counseling and Partner Elicitation (PCPE), and Public Information. All components of the prevention program are planned through a community planning intiative mandated by the CDC in 1993.

Community Planning

Community planning is the process that enables local communities to identify, plan, and determine HIV/STD prevention priorities within their planning areas. Community planning in Texas has evolved from a single decision-making body in 1993, to a body of ten HIV Prevention Community Planning Groups (CPGs) in 1995, and finally to a partnership with sux CPGs that represent the geographic and cultural diversity of Texas (Figure 16). The CPGs are responsible for determining community priorities and intervention strategies based on local needs assessments. The CPGs and the TDH jointly develop comprehensive HIV prevention plans that identify populations with the highest rates of HIV infection and interventions to prevent HIV infection in the identified populations. The TDH uses these plans to allocate HIV prevention funds through a competitive Request for Proposal process.

The goal for each CPG is to include members who represent the unique profile of affected populations within the planning area. An open nomination process for membership ensures parity, inclusion and representation from those most affected by HIV, such as those who are affected, infected and at highest risk for HIV infection; persons with expertise in social and behavioral science and epidemiology; and local HIV prevention workers. Members of the CPGs represent the cultural, ethnic and other diversities of the Texas population most affected by HIV and AIDS within each planning area.

Figure 16 Texas HIV/STD Planning Areas



In March 2002, the six CPGs completed the development of six new Area Action Plans (AAPs) that were submitted to CDC in the fall of 2002 and will be implemented in January 2003. These AAPs reflect a new format with priority populations listed in rank order by rates of infection within the high and low morbidity zones of each of the six plan areas. Specific interventions are listed for each population. The selection of interventions was based on the behavioral risk factors of the populations. The AAPs are available for viewing at www.tdh.state.tx.us/hivstd/areaplan/default.htm.

Accomplishments

- In December 2001, TDH Planning Staff and CPG Co-chairs participated in the planning and delivery of a statewide capacity-building conference to promote the changes in HIV prevention programming in Texas.
- TDH provided technical assistance to CPGs to improve the ability and capacity to produce locally representative HIV prevention plans. The technical assistance included assistance in analysis of epidemiologic data, guidance in utilizing behavioral science in selecting interventions, and needs assessment data interpretation.
- The CPGs performed the following activities to prepare for the writing and completion of AAP completed in 2002:
  - Reviewed HIV Epidemic Profiles that were produced by the Bureau's Research and Program Evaluation Branch
  - Conducted a targeted needs assessment using a standardized client survey tool
  - Developed and conducted a resource inventory
  - Reviewed needs assessment data that was collected during the year
  - Reviewed prevention intervention literature and compendia to improve the selection of targeted and specific prevention interventions for identified at high-risk populations

Future Plans and Initiatives

The following goals were adopted for the community planning process in Texas. CPGs and TDH will assess these goals within the five-year period (2003 – 2007) of the new AAPs:

- Develop and implement a community assessment continuum of core elements, which also allows for localization.
- Strengthen the CPGs by allowing maximization of technical assistance resources and utilizing appropriate providers.
- Collaborate with Ryan White Planning Councils, Ryan White Title II Assemblies, and other HIV/STD planning groups by exchanging information, by mutual participation in local planning activities, and through the integration of processes where feasible.
- Examine the role of CPGs in comprehensive prevention planning for STDs, HCV, and TB.
- Ensure fidelity with the PIR principles beyond the minimum standards.

Health Education and Risk Reduction

The goal of the HERR component of prevention is to educate persons at "high-risk" for HIV about disease transmission, assist them in establishing realistic and personalized risk reduction plans, and to provide them with the skills and practice of these skills necessary to prevent transmission of HIV. During 1998, TDH staff developed and managed a competitive application and review process for selecting HERR contractors who began providing these services for their communities in January 1, 1999. This competitive application was based on plans developed by the ten community planning groups, using the process outlined in the previous section. These plans will remain in place until the new planning stage, finalized in the spring of 2002, is implemented in January 2003.

During 2001, both local health departments and community-based organizations provided HERR services. These contractors targeted one or more of the specific populations named in their AAPs (e.g., IDU, M/MS, men and women at risk through heterosexual transmission (F/MS), etc.), and provided these populations with educational interventions with demonstrated effectiveness that were culturally sensitive, language-appropriate, and appropriate to the settings in which the clients are encountered. In keeping with the guidance provided by the communities' plans, the majority of the HERR direct delivery staff were peers to the populations they served[2], which helps establish and maintain the rapport necessary for effective communication. They conducted activities in a variety of sites, such as community hangouts, streets, parks, local jails, STD clinic waiting rooms, local health department clinics, and other local agencies.

TDH staff provided technical assistance, as well as conducted monitoring of HERR contractors. In addition, TDH staff provided assistance to organizations to help them evaluate their programs and demonstrate the effectiveness of their interventions. This ensures that contractors are effective in their implementation of HIV prevention interventions and that contract dollars are spent in accordance with accepted contract objectives. Another important role of this component is to provide ongoing information and HIV educational material to both contractors and non-contractors for distribution to the general public.

Accomplishments

- HERR contractors provided 246,161 educational contacts to M/MS, IDU, and high-risk heterosexuals in a variety of community-based settings. This represents a 55% increase in education-only contacts in 2001 compared with those reported in 2000.
- HERR contractors also provided 132,548 skills-building contacts to M/MS, injection drug users, and high-risk heterosexuals in a variety of community-based settings. This represented a 20% decrease in skills-development contacts in 2001 over those reported in 2000.
- HERR contractors distributed over 3.9 million condoms throughout the State.
- TDH continues to use the HERR reporting system to assist in identifying gaps in services and unmet needs for HIV and STD prevention services throughout the State.

Future Plans and Initiatives

- As a result of a competitive RFP, responsive to the AAPs developed by the six Community Planning Groups, TDH will be implementing 19 group- and individual-level interventions at multiple locations throughout the state beginning in January 2003. Eighteen of these have been demonstrated, through rigorous peer-reviewed evaluation research to be effective at reducing HIV and

[2] Peer means that the worker was either a member of the group being targeted (e.g., gay man, former injection drug user, Hispanic woman) or is sensitive to and experienced with the issues affecting that population.

STD risk behaviors. The final intervention is reputationally strong, and will be closely monitored for effectiveness by TDH and its evaluation partner at the University of Texas, Southwestern Medical Center in Dallas (UTSMC). TDH continues to emphasize the importance of peer education, and outreach designed to recruit high-risk individuals into these resource-intensive interventions. This represents a fundamental change in how TDH implements HERR activities in the state, from a outreach model toward providing services demonstrated to be effective and providing those services to those individuals at highest risk, in order to reduce the greatest number of HIV infections.

- ❖ With the cooperation of UTSMC, TDH will finalize methods and training to assist providers in evaluating HERR interventions and programs for quality improvement and to assist in demonstrating the effectiveness of activities, and monitor the outcomes associated with these programs.
- ❖ TDH will complete modifications of its HERR reporting system to come in compliance with CDC guidance, and more effectively support providers process evaluation efforts.

Prevention Counseling and Partner Elicitation

TDH provides Prevention Counseling and Partner Elicitation (PCPE) services throughout the State through contracts with local health departments and community-based organizations. Prevention counseling is client-centered, interactive and responsive to individual client needs. The focus of prevention counseling is on developing prevention goals and strategies with the client rather than simply providing information. Counselors must understand the unique circumstances of each client (e.g., behaviors, sexual orientation, race/ethnicity, culture, knowledge level, social and economic status). Counselors engage clients in Test Decision Counseling, a process to help clients reach their own decisions about whether to test for HIV, that includes assessing and supporting client readiness for testing and coping with the results.

When clients return to learn their test results, they receive personal post-test prevention counseling. If the client tests negative for HIV infection, results counseling reinforces behavior changes identified by the client to keep from becoming infected. If the client tests positive for HIV, post-test counseling encompasses a range of issues including referrals to medical, psychological and social services. The counselor also elicits the names of sex and/or needle sharing partners in order to assist the client in ensuring these partners are notified of their potential exposure to HIV and offered the opportunity to receive counseling and learn their HIV status. Trained DIS at local health departments or the clients conduct these notifications. Finally, post-test counseling reinforces behavior changes the client has identified to maintain personal health and prevent transmitting the infection.

TDH staff provide technical assistance and monitoring to contractors to ensure compliance with objectives and appropriate use of program funds. TDH maintains PCPE data collection and reporting systems that provide important information for planning and implementing prevention activities. Each time an initial counseling session is done with a client, the counselor fills out a standard machine-scannable bubble form that contains demographic and mode of exposure[3] information about the client, as well as information about the counseling session (e.g., date, if an HIV test was performed, result of HIV test, if

[3]Most PCPE clients have multiple risks for HIV. Mode of exposure is a way of categorizing clients by the risk behavior that they report that is most likely to expose them to HIV. The modes of exposures are listed in order of risk of transmission of HIV, beginning with the riskiest. The modes are: 1) male to male sex with injection drug use (M/MSIDU), 2) male to male sex (without injection drug use) (M/MS), 3) injection drug use (without male to male sex) (IDU), 4) heterosexual sex (F/MS), 5) other tissue/blood exposures (e.g., occupational exposures, transplants), and 6) no indicated risk for HIV (NIR).

Table 3. Publicly Funded HIV Tests and Positives by Sex and Race/Ethnicity

	Male		Female	
	Tests (%*)	Positive (%*)	Tests (%*)	Positive (%*)
White, non-Hispanic	20,987 (34.5)	317 (31.1)	16,655 (33.2)	62 (19.2)
African American, non-Hispanic	17,292 (28.4)	394 (38.6)	14,099 (28.1)	182 (56.3)
Hispanic, all races	21,424 (35.2)	295 (28.9)	18,389 (36.7)	75 (23.2)
Asian/Pacific Islander	9 (0.0)	0	9 (0.0)	0
American Indian/Native American	551 (0.9)	2 (0.2)	441 (0.9)	1 (0.3)
Other, multiracial	182 (0.3)	6 (0.6)	172 (0.3)	1 (0.3)
Unknown/Missing	448 (0.7)	6 (0.6)	328 (0.7)	2 (0.3)
Total	60,893	1,020	50,093	323

* Small numbers make proportions unstable.

client returned for follow up counseling). These forms are submitted to TDH, where they are compiled and analyzed, and the data are forwarded to the CDC in Atlanta.

In FY 2001, contractors reported 118,717 initial counseling sessions. Fifty-five percent (55 percent) of these sessions were with male clients, and 45% with females.

During 2001, 94% of the initial counseling sessions included an HIV test. Of these tests, 41% were for clients who had never tested for HIV before. For every 100 tests performed, 1.2 were HIV positive. This rate is a slight decrease over the positivity rate reported in 2000 (1.3 positives / 100 tests). The race/ethnicity and mode of exposure of the men and women who tested and who tested positive for HIV are shown in Tables 4 and 5. Positivity rates were nearly two times higher for African Americans than Hispanics and Whites, and rates of positivity were nearly three times higher for men compared to women (1.7 positives per 100 tests for men, 0.6 positives per 100 tests for women). Across risk groups, men who reported sex with men and using injection drugs (M/MS/IDU) and M/MS had positivity rates four times higher, each, than IDU and five times higher than F/MS. The race/ethnic distribution of women testing HIV-positive is especially noteworthy: African-American women make up 28% of the HIV tests done for women, but 56% of the positive tests were among African American women.

Legislative action in 1999, House Bill 1652 released funds for hepatitis C (HCV) counseling and testing to be performed at selected prevention counseling sites throughout the state. In 2001-2002, 14,350 HCV tests were performed with 2,732 positive tests. Over three-quarters of all HCV positive clients have use injection drugs, and 12% reported unsanitary piercing or tattooing as the most-likely mode of exposure to HCV. Current and former IDU testing for HCV at TDH-funded sites have a positivity rate for HCV of 50%.

Accomplishments

- In 2001, TDH staff assisted the City of Houston with training its personnel on database management of the PCPE system (Note: the City of Houston receives separate funding for its HIV prevention efforts from TDH and is responsible for its own community planning process, data collection, and monitoring process).
- PCPE contractors provided 118,717 initial counseling sessions in 2001. Of these 1,343 were positive for HIV. This positivity rate, 1.2 positives per 100 tests, was slightly lower than the rate in 2000.
- More than 60% of the HIV-positive clients counseled at PCPE contractor sites who returned for their test results were successfully referred to medical care and social services for their HIV infection.

Table 4. HIV Tests and Positives by Sex and Mode of Exposure BDTP - Risk Since 1978 * Result of Test * Client's sex Crosstabulation Count

	Tests (%*)	Positive (%*)	Tests (%*)	Positive (%*)
M/MS/IDU	1,352 (2.2)	55 (5.4)	—	—
M/MS	12,330 (20.2)	533 (52.3)	—	—
IDU	8,485 (13.9)	108 (10.6)	5,950 (11.9)	42 (13.0)
F/MS	37,988 (62.4)	313 (30.7)	42,968 (85.8)	273 (84.5)
NIR	738 (1.2)	11 (1.1)	1,175 (2.3)	8 (2.5)
Total	60,893	1,020	50,093	323

* Small numbers make proportions unstable.

Future Plans and Initiatives

- ❖ TDH will continue to work with providers through training and individual technical assistance to increase the proportion of those individuals who receive an HIV test to return for results counseling to learn their HIV status.
- ❖ TDH will continue to increase efforts to ensure that those clients who test positive for HIV are successfully linked into a system of care.
- ❖ PCPE contractors will continue to use counselors who are peers of the targeted populations in order to expand accessibility.
- ❖ TDH will complete an extensive review of the prevention counseling model, develop updated training for counselors, and evaluate new tools for counselors and supervisors to use which will increase the quality of counseling statewide.
- ❖ TDH will implement the modified PCPE reporting system which will allow providers to have real-time reports of prevention counseling contacts and will merge the current PCPE reporting system with the HCV supplemental reporting system, reducing reporting burden of providers.

HIV SERVICES

The reauthorized Ryan White CARE Act Amendments of 2000 made legislative changes designed to improve and expand access to care, increase accountability, and enhance service capacity in underserved urban and rural communities. Primary themes in the new legislation include:

- Improved access to care for persons living with HIV aware of their serostatus but not in care.
- Quality management and health services.
- Capacity development for planning councils, States, and CARE consortia.
- Targeting resources to meet the needs of underserved communities/populations increasingly affected.
- Coordination and linkages with other publicly-funded programs such as Medicaid, State Children's Health, Insurance Programs, Maternal and Child Health Programs, Community Health Centers, and providers of services to the homeless and substance user.

Texas initiated a project in May 1997 to develop a statewide coordinated statement of need (SCSN) for HIV/AIDS service delivery throughout the State. In addition, the project promotes communication and cooperation between those who are planning the delivery of services to those affected by HIV/AIDS and the various regional CPGs. A steering committee structure has guided the implementation of the Texas SCSN planning activities. The SCSN Steering Committee includes clients and persons living with HIV and AIDS, and representatives from Ryan CARE Act Titles I, II, III, IV, Part F programs, CPGs, and TDH. The 17-member steering committee also represents the cultural, ethnic, age, gender, and geographic diversity of Texas. The SCSN meets on a quarterly basis to review the progress of the project, address concerns, and identify future goals and objectives for the project.

The overarching goal of the project is to collaborate in the development of a SCSN for HIV/AIDS service delivery and infrastructure at the local and state levels of the State of Texas. This goal is based on the expectation that collaboration and coordination will strengthen the capacity of HIV/AIDS service providers to provide more efficient services while also helping to identify significant cross-cutting issues that must be addressed at the local and state levels.

Service Delivery

In FY 2002, the Bureau of HIV and STD Prevention distributed over $20.6 million in HIV services contracts throughout the State. To award HIV services funds as extensively and equitably as possible, the Bureau divides the State into 26 HIV Service Delivery Areas (HSDAs) and seven planning areas. TDH contracts with administrative agencies to manage the delivery of services. The funds available to each HSDA are determined through a new funding formula based on three factors at the following weights:

- 50% Number of reported living cases of HIV and AIDS in the HSDA;
- 30% Number of unduplicated clients receiving at least one publicly-funded service in three non-consecutive, randomly selected months from July 1999 through June 2000;
- 20% Percent of the HSDA population that is eligible for Medicaid (indicates economic distress of a community and is highly correlated with poverty).

Basic HIV services supported by TDH contracts with local health departments and community-based organizations include: ambulatory/outpatient medical care, hospice care, case management services, insurance assistance program, dental care, nutrition services, medications, home health care, mental health therapy, substance abuse treatment/counseling, and support services such as direct emergency financial assistance, food bank, housing, and transportation.

Physical and mental health services enable HIV-infected persons to remain healthier and independent, extending the time they can care for themselves and others without support. HIV services reduce the need for expensive hospitalizations and more costly treatments by providing preventative services and less costly home-based care. Since many HIV/AIDS clients are impoverished by the disease, they must rely on publicly-funded care. Providing cost-effective HIV services benefits all Texas residents by reducing health care costs supported by taxpayers.

Accomplishments

- ❖ Continued seven Ryan White Services Projects specifically to reduce barriers and improve access to HIV health and social services for underserved and emerging populations.

- In FY 2002, TDH received $135,232 in supplemental RW funds for the federally-defined emerging community of El Paso. These funds were contracted to Centro De Salud Familiar La Fe for the following services: Medication/Drug Assistance, Health Insurance Reimbursement, Direct Financial Assistance and Dental Services.
- Published the Ryan White Title II Plan for the use and distribution of Ryan White Title I Twelfth Year funds.
- TDH renewed projects to establish and maintain participation by minorities in the Texas HIV Medication Program (THMP). A total of $454,839 per 12-month period was earmarked for this program. The target populations served are African Americans, Hispanics and others with HIV in the State's two highest morbidity counties, Harris and Dallas, who are: (1) incarcerated in federal, state or local adult and juvenile institutions, or (2) recently released back into these two counties.
- In collaboration with the Unit Cost Technical Assistance Center at Dallas County Health and Human Services Department, drafted a unit cost capacity assessment toll for HIV services Administrative Agencies and services providers.
- In March 2002, along with TDH Grants Management Division, convened a financial workgroup to develop a technical assistance manual for financial staff of Administrative Agencies and service provider levels regarding unit cost reimbursement for HIV services.

Future Plans

- TDH will continue to respond and adapt to the growing impact of the HIV/AIDS epidemic among underserved and minority hard-to-reach populations.
- TDH will continue to ensure access to existing and emerging HIV/AIDS therapies, including new combination and retroviral therapies and prophylaxis.
- Continue to revise the HIV services reporting system to maximize efficiency and effectiveness.
- TDH will continue to fund Ryan White Services projects that are specifically targeted to reduce barriers and improve access to HIV health and social services for underserved and emerging populations.

Housing Opportunities for Persons with AIDS (HOPWA)

The Housing Opportunities for Persons with AIDS (HOPWA) programs provides emergency housing assistance and rental assistance to eligible persons with HIV/AIDS and their families. The primary objective of HOPWA is the provision of assistance to continue independent living for persons with HIV/AIDS and their families in Texas. During this reporting period, TDH received $2,529,000 in funds from the U.S. Department of Housing and Urban Development for the HOPWA program. Twenty-five of the State's 26 HIV Service Delivery Areas (HSDA), receive HOPWA funding through an administrative agency serving the HSDAs.

The Emergency Assistance Program provides short-term rent, mortgage, and utility payments to prevent homelessness. This program enables low-income individuals with HIV that are at risk of becoming homeless to remain in their current residences for a period not to exceed 21 weeks in any 52 week period. The Rental Assistance Program provides tenant-based rental assistance, including assistance for shared hous-

ing arrangements. It enables low-income clients to pay their rent and utilities until there is no longer a need, or until they are able to secure other housing.

Accomplishments

- In FY 2002, the HOPWA program provided assistance to 2,939 persons with HIV/AIDS and their families; an increase of 76 persons from the previous year's reporting period.

VI. STD PREVENTION AND SERVICES

STDs are a major threat to the health of Texans. Young women and their children are especially at high risk for STDs and the resultant complications. Babies born to infected mothers are often the ones to suffer the most from STD infections. STDs such as syphilis and HIV can be passed to the fetus through the mother's blood while she is carrying the child or transmitted at delivery. Others, such as gonorrhea, chlamydia and herpes, may also be transmitted to the newborn at the time of delivery. STDs in children can lead to fetal death, retardation, crippling, blindness, deafness, pneumonia and low birth weight. STDs in women can lead to chronic debilitating pain, ectopic pregnancy, sterility, cancer, and death. Adolescents are at higher risk for acquiring STDs for several reasons: a tendency to have multiple partners, to have unprotected sex, and to select partners who are at high risk. Adolescent women have a physiologically increased susceptibility to infection; furthermore, teenage women have steadily increased their number of premarital sexual encounters during the past two decades. At the same time, adolescents often encounter the most obstacles to seeking health care. STDs are a particularly significant health problem for economically disadvantaged minority populations.

For every $ spent on early gonorrhea and chlamydia dectection and treatment, $12 in associated costs could be saved.

The goal of the STD prevention and services program is to prevent the spread of high priority STDs such as syphilis, HIV, chlamydia, and gonorrhea. The foundation of this effort is built on six primary components: community/individual behavior change; surveillance/data management; partner services/disease intervention; medical/laboratory services; leadership/program management; and training and professional development. Five of these components are discussed below; training and professional development activities are addressed in the Training and Public Education section of the report.

Dramatic changes in the health care industry in recent years have meant that health departments no longer serve as sole source providers of STD prevention and control services. The responsibility for STD service delivery has been increasingly spread among members of private health care systems, such as HMOs. The Bureau undertakes activities to empower communities in the identification and meeting of these needs. STD program personnel around the State participate in HIV Community Planning Groups and collaborate with community based organizations to provide outreach, screening and treatment services to at-risk populations in non-traditional settings. Of particular note are the Texas Infertility Prevention Project (TIPP) and the Syphilis Elimination Project (SEP). The TIPP provides resources to eighteen local health departments, Title X Family Planning Clinics, and adult and juvenile detention centers for the screening and treatment of women and their partners for chlamydia and gonorrhea. The SEP funds the Dallas County, Houston and San Antonio Metropolitan Health Departments, as well as local community coalitions, for enhanced outreach and disease intervention activities.

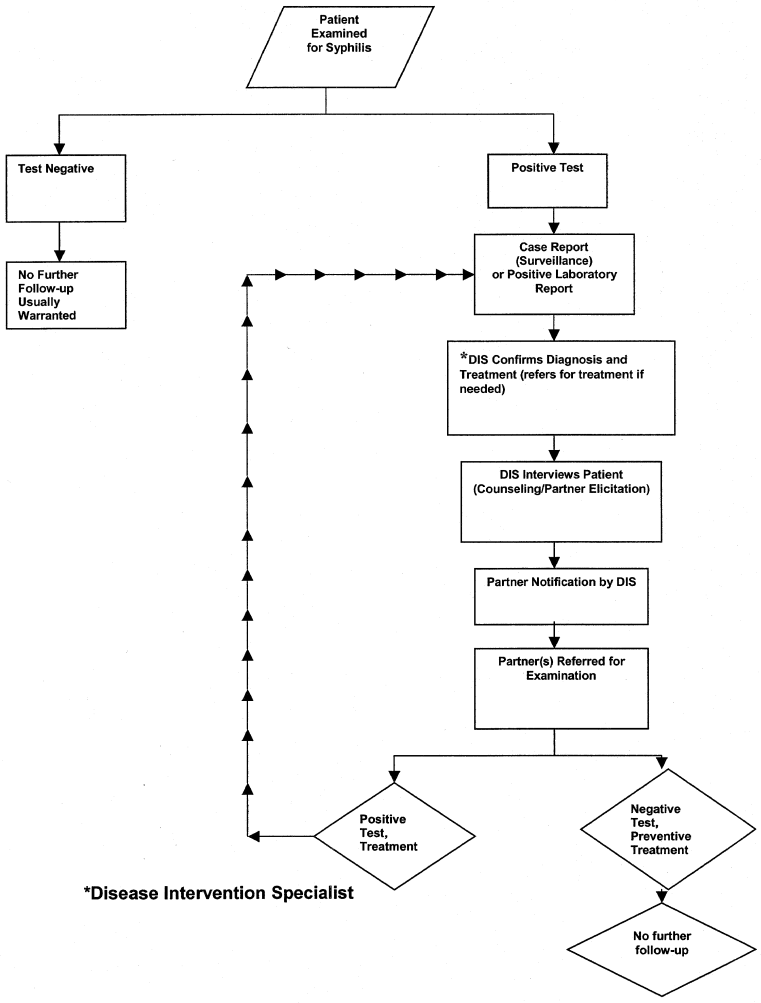
Surveillance, the collection and analysis of data about the occurrence of disease, is crucial to the success of any disease control effort. Health care providers and laboratories in Texas are required to report syphilis, gonorrhea, chlamydia, chancroid, AIDS, and HIV infections. Analyzing case reports provides information needed by TDH and local health departments to plan appropriate prevention and control activities and predict disease trends. The Bureau uses the STD Management Information System, a CDC-developed computerized morbidity surveillance system. Both TDH regional HIV/STD programs and local health department programs collect disease reports within their jurisdiction, and transmit the information to TDH. TDH monitors the extent of the statewide STD problem and changes in demographic and geographic

distribution of cases. This information is used to prioritize needs, allocate program resources, and plan and direct activities to respond to changing conditions.

Highly trained DIS routinely perform syphilis and HIV counseling/interviewing, case management, and partner notification activities for individuals with STDs. In certain locales where resources permit, they also perform targeted gonorrhea and chlamydia case finding, as well as targeted prevention counseling, to clients identified as high risk for STDs. PCPE activities are routinely performed with infectious syphilis and HIV-infected individuals. PCPE is conducted with both gonorrhea and chlamydia clients as resources allow.

The disease intervention process usually begins when a DIS receives a report of an infected or at-risk client. The DIS locates the person, refers him/her for examination and treatment, and counsels him/her on methods to reduce the risk of acquiring or transmitting STDs and HIV in the future. The DIS elicits the names, addresses, and other locating information of sex and/or needle sharing partners, and through field investigation, locates and refers these partners for examination, treatment and/or counseling. The cycle (**see Figure 17**) continues with the identification of each infected partner. When a contact is notified, they are <u>not</u> told who identified them as a potential contact. All disease intervention activities are completely confidential. TDH funds disease intervention activities through its regional programs and through contracts with eleven local health departments.

Figure 17. The Disease Intervention Process



The Bureau purchases and distributes medicines for the treatment of priority STDs to regional and local health departments and other key providers through the Clinical Resource Division's Texas HIV Medication Program, which is highlighted later in this report. The Bureau provides resources for screening high risk clients for gonorrhea, chlamydia, HIV and syphilis through the State laboratory system and occasionally funds private physicians to examine and treat STD patients in areas where no publicly funded facilities are available. TDH also funds STD examinations and treatment at three Baylor College of Medicine Teen Clinics in Houston, which serve high risk adolescent females who otherwise would not seek health care. This partnership ensures that at-risk teenagers in Houston have access to needed STD services.

TDH's leadership and management keep the program focused on maintaining high standards for STD contractors around the State and acquiring the technical skills and knowledge to remain proactive in a changing health care environment. TDH has developed guidelines and established standards for STD program performance. Regional and local STD programs provide detailed reports on morbidity and progress on objectives semi-annually.

Accomplishments

- DIS interviewed and managed 1,363 early syphilis cases during 2001; as a result of disease intervention activities among high risk associated individuals (i.e. partners), 455 new cases of syphilis were identified and treated, and 803 persons were preventively treated for syphilis.
- 2001 was the third year of CDC funding for the Syphilis Elimination Project, which enhances syphilis outreach, screening and surveillance in the State's High Morbidity Areas (HMAs), Dallas and Harris counties. As part of the project, TDH, as well as local STD Programs in the HMAs, developed and implemented state and local Syphilis Elimination Plans, which include Rapid Response Plans to facilitate containment of unusual increases in syphilis morbidity. Community coalitions made up of public and private organizations representative of and serving populations affected by syphilis participated in development of local plans and joined local health departments in outreach and screening activities among high risk populations.
- Screening for syphilis was increased in adult and juvenile corrections facilities in the two HMAs, as well as in Bexar County, where an unusual increase in syphilis cases began during 2000 and continued through 2001. Austin, Amarillo, and Wichita Falls also experienced unusual increases in syphilis cases during 2001.
- DIS provided PCPE to 1,193 HIV-positive individuals in 2001, resulting in the location, counseling, and testing of 1,679 HIV sex/needle sharing partners and the identification of 171 new HIV infected persons. DIS successfully referred 1,064 (89.2 percent) of the HIV-positive individuals to early intervention services.
- During 2001, the gonorrhea screening program tested 291,981 persons, identified 11,197 positives (3.8 percent) and confirmed treatment on 10,804 (96.5 percent) of those infected. The chlamydia screening program tested 296,142 persons, identified 21,417 positives (7.2 percent) and confirmed treatment on 20,757 (96.9 percent).
- Through the CDC-funded Texas Infertility Prevention Project, the Bureau of HIV and STD Prevention collaborated with the TDH Bureau of Laboratories, the TDH Family Planning Division and its family planning contractors to provide STD screening and medication to clients statewide.

- In 2001, TDH regional STD programs and state-funded local STD programs conducted 534 presentations to local, state, national and international audiences, reaching a total of 24,093 individuals.
- TDH has been active in promoting the use of electronic laboratory reporting to accelerate case reporting and enhance the disease intervention process. Ten laboratories utilize electronic laboratory reporting, making electronic reports available daily to local health departments in Dallas, El Paso, Fort Worth, Houston, San Antonio, Waco, Wichita Falls, TDH's Division of Infectious Disease Epidemiology and Surveillance Branch (IDEAS), and TDH Public Health Regions 1, 7, and 8. The HIV/STD Surveillance Branch disseminates paper-based reports to the remainder of local health departments in Texas.

Future Plans and Initiatives

- Local and regional STD programs will continue to collaborate with public and private organizations such as jails, youth detention centers, homeless shelters, and neighborhood health facilities to provide outreach and screening for populations at risk for acquiring and transmitting STDs.
- Collaborative activities for 2002 will include continued exploration of additional areas for STD and HIV coordination to best utilize program resources and improve or expand delivery of services, especially regarding women offered STD screening outside of STD clinics.
- TDH will continue to urge high volume laboratories around the State to institute electronic laboratory reporting, including the TDH laboratory, which serves many local and regional STD programs.
- TDH will continue implementation of its Syphilis Elimination Plan, responding rapidly to increased syphilis morbidity by working with affected communities to enhance outreach, screening, and disease intervention activities.

VII. TRAINING AND PUBLIC EDUCATION

The overall mission of the Training and Public Education Branch (TPEB) is to develop and provide accurate, specialized HIV/STD information and training to diverse audiences using effective and appropriate methods of communication and education. To accomplish its mission TPEB collaborates with programs across TDH, other State agencies, local health departments, and community based organizations involved in HIV and STD prevention activities.

Specific TPEB activities include providing training courses such as the four-day HIV/STD/Viral Hepatitis PCPE course, the 10-day *Introduction to Sexually Transmitted Disease Intervention* (ISTDI) course, the two-day course *STD Facts and Fallacies*, and the two-day behavioral theory course entitled, *Bridging Theory and Practice*.

Accomplishments

- TPEB staff coordinated the first HIV Prevention Capacity Building Conference held December 4-6, 2002 at the Lakeway Inn in Austin, Texas. The Conference provided an overview of new expecta tions of TDH in prevention services, reviewed regional prevention plans, and provided resources to expand the capacity of organizations to conduct the new resource-intensive preventions. Over 240 potential contractors, regional staff, and Bureau staff attended the conference.

- TPEB developed and began providing a two-hour course entitled *HCV for Nurses*. This two-hour training was developed as a result of recent legislation requiring all licensed nurses in the state of Texas to participate in no less than two hours of continuing education related to HCV. TPEB staff collaborated with the TDH Public Health Nursing Continuing Education Service to develop the training and to complete the necessary forms for receiving certification to provide continuing education hours. The course is designed to assist nurses in analyzing client risk and circumstances to assist them in selecting appropriate HCV transmission risk reduction options, interpreting HCV laboratory results, and identifying appropriate interventions and treatment options.

- The Prevention Training Center III grant application for continued funding was completed and renewed. The contract period is from April 1, 2002 through March 31, 2003. The grant was initially received by TDH, HIV/STD Health Resources in April 2000. The continued funding allows TDH to continue to sub-contract with the Dallas County Health and Human Services to provide partner services training to the southeastern quadrant of the United States (a total of 13 states).

- During FY 2002, TPEB staff began the process of coordinating a social marketing campaign targeting women of childbearing age with HIV infection or at high risk for HIV infection. The primary goal of the campaign is to raise awareness among pregnant women and women planning a preg nancy who have HIV or are at risk for HIV infection about the benefits of prenatal care (including HIV counseling and testing) as a viable, valued and desired option. This campaign is part of a Department wide collaboration to reduce the rate of perinatal HIV transmission. TPEB contracted with Sherry Matthews Advocacy Marketing to conduct pre-campaign focus groups among women of childbearing age with HIV infection or at high risk for HIV infection in urban and rural settings to assess their knowledge, attitudes, beliefs, and behaviors to guide the campaign's development. The campaign pilot is scheduled to roll out in early 2003.

- TPEB staff answered approximately 577 public information requests (PIRs) during FY 2002, not including requests taken through the HIV/STD InfoLine. The majority of PIRs included requests for HIV/STD educational materials, community resource directories, HIV/AIDS/STD surveillance and

seroprevalence data, conference information, and administrative information (policies/rules/guide lines).

- During FY 2002, TPEB updated and revised the 2002-2003 edition of the Texas HIV/STD Community Resource Directory (CRD). This 250-page resource booklet will list HIV and STD services, informational and educational resources available in Texas, and around the country. It will be available in late October 2002. The CRD is free of charge to the public.

- During FY 2002, TPEB staff worked to consolidate and optimize the Bureau's stock of HIV/STD educational materials in the TDH Warehouse. Materials identified as redundant were eliminated, while materials that could be easily photocopied were converted to fact sheets and made available on the Bureau Web site for downloading as Adobe PDF files. This consolidation saved the Bureau approximately $25,242.00 on printing costs, opened up space in the TDH Warehouse, and offered our customers instant access to educational materials.

- TPEB initiated a Capacity Building Workshop Series based on feedback received at the Capacity Building Conference and other stakeholder input. The four core classes of the Series include: *The Perfect Brainstorm* focusing on the value and the mechanism for helping a group think beyond the mundane and generate exciting new ideas; *The Strategic Shift,* which examines an issue or problem HIV/STD Prevention programs and/or program staff deal with on an on-going basis. Participants brainstorm ideas and solutions to the problem, then brainstorm barriers to implementing one or more of the solutions and ultimately, work together develop ideas and ways to overcome the barriers; *Systems Thinking / Systems Changing,* a "hands-on" simulation that provides training and experience in planning for and managing continuous change and improvement in a community; and *Facilitation for Lasting Change,* which develops the skills of a facilitator to move stakeholders beyond conflict to a decision in order to achieve a lasting change. Participants learn about the life cycle of conflict, styles of decision-making and the key tools of effective facilitators.

VIII. HIV/STD CLINICAL RESOURCES

The Clinical Resources Division (CRD) is currently composed of three programs: the Texas HIV Medication Program (THMP), the Clinical/Case Management and Administrative Compliance Program, and the Early Access to Clinical and Preventive Care Services Program (EACPS). The CRD is also responsible for administering the HIV/AIDS Interagency Coordinating Council.

The primary mission of the CRD is to enhance the lives of individuals with HIV disease or other STDs by providing life-sustaining HIV medications or curative medications to treat other STD conditions, and to ensure that high-quality ambulatory medical care and case management services are available and accessible.

THMP

The THMP is responsible for the purchase and distribution of medications for the treatment of HIV disease and other STDs. The program also provides medications for the treatment of opportunistic infections for people with HIV disease. Medications for the treatment of HIV disease are provided to clients through a network of pharmacies statewide. The HIV Medication Advisory Committee is also administered by the THMP.

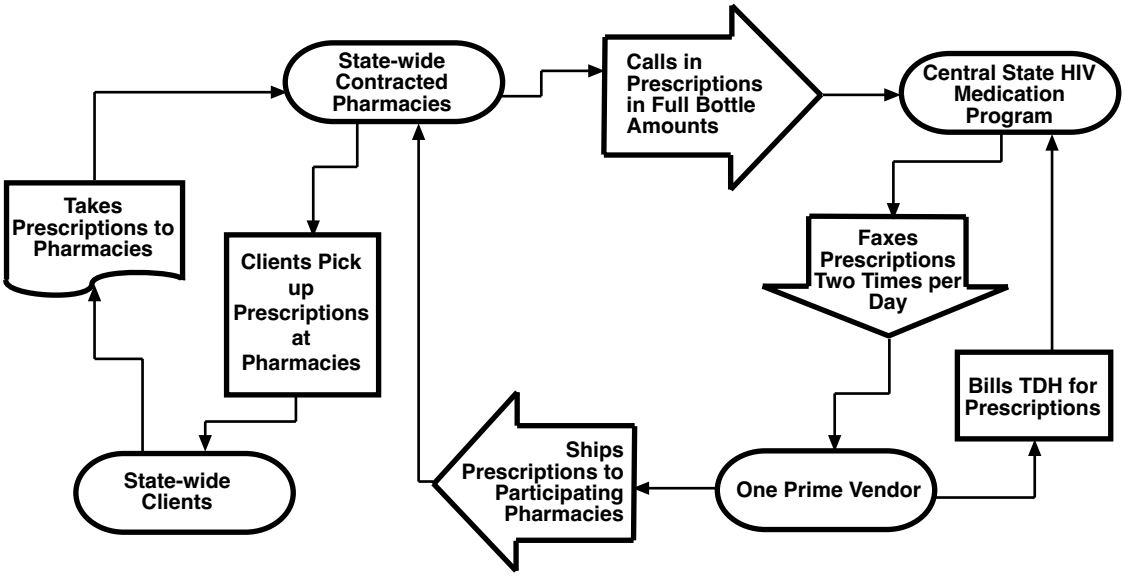
THMP Budget Needs

The THMP is anticipating a substantial budgetary need beginning in September 2004, based on current trends in the numbers of clients enrolling in the Program as well as the increasing cost of medications.

In an effort to respond to the questions and concerns from our clientele and other stakeholders, the Bureau of HIV and STD Prevention held a series of meetings statewide (Houston Eligible Metropolitan Area (EMA), San Antonio EMA, Austin EMA, Dallas EMA and Fort Worth EMA) during the summer of 2002. Seventy-four percent of the Program's clients currently receiving medications reside in one of the preceding five Title I EMA cities visited. Additionally, the Bureau developed several strategies to address these funding issues including: examining the internal efficiencies and cost savings that could be achieved within the TDH, seeking financial assistance from outside resources, and as a last resort, making changes in the THMP, which could include modifying the current formulary, limiting the cost per client of medications provided, developing a sliding fee scale, changing the current eligibility criteria, or closing the program to new clients and developing a waiting list.

In August 2002, the Bureau of HIV and STD Prevention, with the support of the THMP Medication Advisory Committee, proposed a change to the financial eligibility criteria for accessing the THMP. Based on actuarial projections, the proposed change is predicted to adequately reduce the projected budget deficits. This change was recommended to the Commissioner of Health. Subsequently, the Board of Health received a formal recommendation to revise the THMP rules regarding financial eligibility criteria. The recommended rule change is currently in a public comment period and a public meeting was held to accept these comments. The proposed rules will move forward to the Board of Health for consideration of approval.

Figure 18 The Texas HIV Medication Program



Accomplishments

- Served a total of 12,298 unduplicated clients during FY 2002.
- Filled a total of 230,122 prescriptions during the fiscal year.
- In August 2001 the THMP began a pilot program to revise the way that client medication orders are distributed to participating pharmacies. The THMP will begin working with a new contracted wholesaler, McKesson, who will drop ship bulk medication purchases at a discounted rate to the TDH Pharmacy Division. The initial pilot study will begin in September 2002; during that time, the five cities with the greatest burden of HIV disease (Fort Worth, Dallas, San Antonio, Houston, and Austin) will each be phased in for medication distribution by the TDH Pharmacy, while the rest of the state continues to be serviced by the previously contracted wholesaler, Cardinal Health. Once the pilot phase is completed, the TDH Pharmacy will assume statewide THMP medication distribution on October 14, 2002. The change in distribution will allow for greater control over inventory, faster order processing and accuracy of shipments, as well as a guaranteed discount of at least 2% below the Public Health Service 340B discounted price, maximizing cost effectiveness for the THMP.
- The development and implementation of the new software system for the THMP continues to progress and evolve. The initial plans have been modified to include a multi-phased rollout that will begin in December 2002 after parallel testing has been completed. The first phase of the new system will allow THMP staff to use a single data collection system for their daily activities, rather than the patchwork system of multiple databases currently in use, and should be fully operational by January 2003. The second phase will incorporate the Pharmacy Inventory Control System and allow pharmacy sites to place orders online, which should be accessible in the summer of 2003.

Clinical/Case Management and Administrative Compliance Program

The Clinical/Case Management and Administrative Compliance Program is responsible for conducting quality assurance reviews of state funded grantees that provide ambulatory medical and/ or case management services to individuals with HIV disease, and providers of STD clinical services. To accomplish this, program staff conduct periodic site reviews, provide technical assistance by telephone and on-site as needed, develop and distribute minimum clinical and case management standards, and conduct investigations regarding allegations of client abuse and neglect. The Clinical/Case Management and Administrative Compliance Program also provides consultation regarding HIV disease and other STD's to internal and external health care professionals, including dissemination of the latest research and clinical management information. The nursing staff also manages requests for clinical consultation and referral from the general public and other stakeholders regarding HIV and other STDs.

Accomplishments

- ❖ Conducted 19 on-site visits to clinical and case management service providers for HIV and STD to evaluate the quality of these services, provide extensive technical assistance to clinical and social service staff, and assist in the development of public health infrastructure related to HIV and other STDs statewide.
- ❖ Implemented a restructured delivery system for HIV services funded by the Bureau, in cooperation with other Divisions. Nursing staff have evaluated the capacity of potential administrative agencies for these funds to determine their ability to establish, maintain and monitor ambulatory medical care and social service delivery systems to be funded under the grant. Staff assisted in establishing contract restrictions related to clinical and social service delivery, and negotiating contracts and budgets with new administrative agencies statewide. Since the summer of 2001, nurse consultants have also participated actively in the restructuring of HIV Service Planning Assemblies in each planning area to allow the local communities to assess the need for critical ambulatory medical and social services, to prioritize service funding and to make funding allocations.
- ❖ Initiated a process of intensive technical assistance and consultation with the Abilene HIV Service Delivery Area and Tarrant County Health District, the Ryan White Administrative Agency (AA) for the area. CRD participated in the competitive process for HIV ambulatory medical and related services by surveying potential contractors to determine their capacity to deliver high-quality client services upon award of the contract.
- ❖ Provided extensive STD clinical technical assistance to a regional health department to develop a protocol for regional STD field workers to provide directly observed therapy (DOT) to people seen in local STD clinics who have laboratory evidence of gonorrhea and/or chlamydia. This model for disease management, based on one used in management of tuberculosis, has subsequently been made available to other regional medical directors for consideration. If successfully implemented, STD DOT has the potential to decrease the spread of gonorrhea and chlamydia by prompt treatment and cure.
- ❖ Coordinated the distribution of Hepatitis B virus (HBV) vaccine to local health departments that provide STD services for use in raising HBV immunization rates amongst clients at high-risk for this disease, in cooperation with Field Operations Branch. Over $83,000 worth of vaccine was

distributed and clinical consultation regarding appropriate vaccination protocol was made available to clinical contractors.

- Developed and distributed STD clinical standards, based on guidance from the CDC, to local health departments and other stakeholders for their use in improving STD programs and clinical service delivery.

- The HIV and Hepatitis Interagency Coordinating Council incorporated a focus on "hepatitis" into the Council's activities, as required by the 77th legislative session, including member educational meetings regarding hepatitis and, in particular, information regarding hepatitis C virus infections. In addition, as one of several stakeholder groups, the Council was given the opportunity to provide input into the Hepatitis C State Plan through convening of a subcommittee of state agencies consisting of the Texas Youth Commission, Texas Department of Protective and Regulatory Services, Texas Department of Criminal Justice, Texas Commission on Alcohol and Drug Abuse, Texas Health and Human Services, Texas Department of Mental Health and Mental Retardation, and the Texas Department of Health.

- The HIV and Hepatitis Interagency Coordinating Council is developing a website to facilitate the coordination of HIV and hepatitis information available to citizens of Texas. The development of this website is consistent with the Council's legislative mandate included in House Bill 768. More importantly, the website will allow those who have a need for HIV and hepatitis information to go to one centralized location and identify all state agencies that may have information, provide services, or have funding for HIV and hepatitis preventive services. The website should be available by the spring of 2003.

- Served on the Department's Bioterrorism Preparedness Team beginning in October 2001 through March 2002. Represented public health nursing (PHN) in developing the Texas Bioterrorism Preparedness & Response Plan.

- The STD Nurse Consultant was selected to serve on a Special Project to assist the TDH Office of Epidemiology to develop and implement a plan for vaccination against smallpox for Texas. The focus of the plan is the pre-event smallpox vaccination of public health and hospital-based staff.

- Served on the Health and Human Services Commission Workgroup to develop a Medicaid 1115 waiver for people with HIV/AIDS to be submitted to the Centers for Medicare and Medicaid. The intent of the funding mechanism is to allow improved access to medical care related to HIV disease by increasing the availability of federal matching funds to four local hospital districts and UTMB Galveston.

- Served on the TDH steering committee to develop the Hepatitis C State Plan, and provided input into and coordinated responses from affected state agencies represented on the Interagency Coordinating Council for HIV and Hepatitis regarding the Plan.

- Provided TDH representation on the Texas Commission on Alcohol and Drug Abuse "Drug Demand Reduction Advisory Committee".

- Contracted with the Texas Oklahoma AIDS Education Training Center (TOAETC) to improve access to prenatal medical care in select Texas communities for HIV-positive pregnant women and women of childbearing age who are at risk for HIV disease. Surveillance data indicate that the number of African American women in this population is increasing at rates higher than other

ethnic groups. Through identification of training needs of clinical providers in East Texas, CRD hopes to increase the capacity of obstetricians and other clinicians to delivery high quality prenatal medical care related to HIV disease. The objective is to advance efforts to reduce HIV transmission between mothers and their babies. A report on the assessment is due from TOAETC by December 31, 2002; TOAETC will utilize other funding sources to provide the medical training as indicated in the report findings.

- ❖ Participated in the second Association for Maternal and Child Health Programs "Prevention of Perinatal HIV Transmission" meeting. The purpose of the meeting was to work in cooperation with the TDH Bureau of Women and Children's Health to develop statewide strategies to reduce the rate of transmission of HIV disease between HIV-positive mothers and their babies in Texas. Team members obtained information from other states on activities and strategies which have helped these states to address issues that are common nationwide. CRD is using tools and strategies gained at the meeting, which includes a model protocol for rapid HIV testing of pregnant women at the time of delivery in order to diagnose and treat previously undiscovered HIV disease in order to lessen the chance that it will be passed on to the newborn.

- ❖ Awarded nearly $454,900 in funds, received through the federal Minority AIDS Initiative, to establish three pilot programs in community-based minority organizations in two Texas counties. The goal of the pilots is to increase access to the Texas HIV Medication Program for HIV-positive persons from minority populations being released from jails and prisons. Under the "Minority Access to the AIDS Drug Assistance Program", three agencies (2 in Dallas County, 1 in Harris County) are establishing intensive case management projects to serve incarcerated and recently released HIV-positive inmates. By gaining access to men and women in the target population prior to release from incarceration, the projects will assist the future client in pre-release planning, and arrange immediate access to HIV medical care and medications through the THMP upon release.

- ❖ Featured the CRD funded program, Get Started of AIDS Foundation Houston, Inc., in a Health Resources Services Administration national policy publication regarding activities funded to improve linkage between HIV-positive, incarcerated persons being released back to the community. The consultant for the publication described the contract performance measures, developed by CRD for the grant, to be the "most clear and concise" of all 16 state projects being included in the national report.

- ❖ Serve on a workgroup with Ryan White Title II stakeholders to further implementation of "Outcome Evaluation" activities in Texas, as required under the Ryan White CARE Act reauthorization relating to Quality Management. The major focus of the Quality Management efforts is ensuring the quality of ambulatory medical care and linkages to critical social services, especially case management.

EACPS

The EACPS, which began in CRD in 1993, provides HIV ambulatory medical and case management services to individuals with HIV disease. With the present success of medication regimes known as "Highly Active Antiretroviral Therapy" in extending the length and quality of life for many people with HIV disease and AIDS, the program focuses on ensuring that people with HIV disease are identified as soon as possible in the disease process, and are successfully referred to medical and preventive clinical services, critical social services, and resources for obtaining HIV medications, as appropriate. Currently, there are eight EACPS projects funded statewide.

Accomplishments

- ❖ Published the EACPS competitive request for proposal (RFP). This RFP replaces the Early Intervention Project grant that has been in place since 1992. EACPS refocuses the almost $750,000 in state funds to ensure that identified HIV-positive people are linked with ambulatory HIV medical care, STD services and critical social services to maintain their health status. Utilized a "predetermination site visit" approach to conduct on-site examination of those agencies that scored highest on the RFP in order to verify the capacity of the agency to provide high quality services if funded.

- ❖ Funded eight sites under the ECPS RFP in geographic locations outside of the five largest cities in the state in order to provide assistance to those communities that have fewer resources available for HIV care.

Interagency Coordinating Council For HIV and Hepatitis

In 2001, the 77th Legislative Session passed House Bill 768 that renamed the HIV/AIDS Interagency Coordinating Council. The Council's new name is the Interagency Coordinating Council on HIV and Hepatitis. The Council's responsibilities include: development of a plan to facilitate coordination of agency programs for prevention of AIDS, HIV infection, and hepatitis; a plan for the provision of services to people infected with HIV, AIDS, or hepatitis, and a report to the Governor and legislature with policy recommendations related to the prevention and delivery7 of health services to individuals who have AIDS, hepatitis or are infected with HIV.

The Council is composed of one representative appointed from each of the following state agencies:

- Texas Health and Human Services Commission
- Texas Department of Health
- Texas Department of Mental Health and Mental Retardation
- Texas Commission on Alcohol and Drug Abuse
- Texas Rehabilitation Commission
- Texas Youth Commission
- Texas Department of Criminal Justice
- Texas Department of Criminal Justice
- Texas Commission for the Blind
- Texas Commission for the Deaf and Hearing Impaired/Hard of Hearing
- Texas Department of Protective and Regulatory Services
- Texas Education Agency
- Texas State Board of Medical Examiners

- Board of Nurse Examiners for the State of Texas
- Board of Vocational Nurse Examiners
- State Board of Dental Examiners
- Texas Juvenile Probation Commission
- Texas Department on Aging
- Texas Workforce Commission

Clinical Resources Division Future Plans and Initiatives:

- ❖ Increase accountability of Ryan White Administrative Agencies related to clinical services, including implementation of required language in requests for proposals and contracts for ambulatory medical and case management services.
- ❖ Work with Ryan White Title I and II stakeholders to develop a coordinated set of standards of care for ambulatory medical services to be utilized for evaluation of the quality of services delivered to consumers.
- ❖ Examine means of achieving greater efficiency in THMP operation, including the possibility of internal reorganization of THMP staff duties and functions.
- ❖ Develop Clinical Practice Guidelines for STDs, other than HIV, and disseminate the guidelines to STD clinical providers statewide.
- ❖ Initiate comprehensive quality assurance reviews of STD clinical providers in high-morbidity areas of the state.
- ❖ Integrate prevention efforts for persons with HIV and other STDs with delivery of ambulatory medical care and treatment for these diseases with a goal of creating improvements in the continuum of care.

IX. APPENDIX

Reported AIDS Cases, January - December 2001

HIV & AIDS: Residence Data				Jan - Dec 2001				
	HIV (Non-AIDS)			AIDS				
Residence County	Cumulative Reported Cases*	Cases Reported in 2000	Jan - Dec 2001	Cumulative Reported Cases**	2001 Rate***	Cases Reported in 2000	Jan - Dec 2001	Persons Living with HIV / AIDS
Region 1	***223***	***86***	***88***	***850***	***7.6***	***73***	***60***	***575***
Lubbock Co.	92	26	28	339	7.4	32	18	244
Potter\Randall Co.	91	48	35	361	12.7	31	28	235
Other	40	12	25	150	4.3	10	14	96
Region 2	***123***	***54***	***37***	***504***	***3.6***	***18***	***20***	***354***
Taylor Co.	33	15	11	150	3.9	10	5	102
Wichita Co.	43	14	13	185	5.3	1	7	130
Other	47	25	13	169	2.7	7	8	122
Region 3	***3,349***	***1,225***	***1,381***	***16,881***	***16.9***	***851***	***947***	***10,956***
Dallas Co.	2,400	838	1,030	12,227	32.0	580	720	7,839
Denton Co.	82	32	30	402	4.2	26	19	275
Tarrant Co.	595	264	194	3,247	8.9	177	131	2,049
Other	272	92	127	1,005	5.4	68	77	793
Region 4/5N	***425***	***160***	***148***	***1,475***	***7.6***	***112***	***105***	***1,147***
Angelina Co.	28	15	5	80	9.9	8	8	67
Bowie Co.	41	11	19	135	3.4	11	3	93
Gregg Co.	68	28	30	202	12.5	23	14	182
Smith Co.	54	21	18	239	10.8	16	19	176
Other	234	85	76	819	6.6	54	61	629
Region 6/5S	***3,780***	***1,395***	***1,372***	***21,913***	***16.3***	***871***	***869***	***12,411***
Galveston Co.	62	31	19	717	9.1	48	23	345
Harris Co.	3,312	1,184	1,215	19,223	21.6	720	747	10,814
Jefferson Co.	163	86	42	613	13.8	36	35	446
Montgomery Co.	64	28	31	270	3.3	9	10	175
Other	179	66	65	1,090	5.1	58	54	631
Region 7	***862***	***323***	***361***	***5,183***	***13.2***	***250***	***311***	***3,163***
Bell Co.	61	28	22	275	10.3	23	25	203
Brazos Co.	50	20	18	173	9.7	12	15	119
Mclennan Co.	67	28	16	298	5.6	13	12	189
Travis Co.	566	211	249	3,762	24.6	162	204	2,220
Other	118	36	56	675	6.0	40	55	432
Region 8	***569***	***277***	***245***	***4,529***	***11.0***	***188***	***240***	***2,745***
Bexar Co.	585	249	211	4,079	14.3	162	202	2,468
Victoria Co.	13	3	6	80	10.6	4	9	50
Other	71	25	28	370	4.3	22	29	227
Region 9/10	***294***	***92***	***133***	***1,721***	***12.1***	***113***	***151***	***1,164***
El Paso Co.	195	51	90	1,206	17.5	80	121	846
Midland Co.	28	9	13	129	4.3	10	5	88
Other	71	32	30	386	5.7	23	25	230
Region 11	***442***	***164***	***181***	***1,888***	***8.7***	***118***	***154***	***1,373***
Cameron/Hidalgo Co.	251	103	105	805	9.8	58	91	705
Nueces Co.	86	21	38	621	11.3	38	36	357
Webb Co.	73	33	24	227	5.0	17	10	185
Other	32	7	14	235	5.1	5	17	126
TDCJ ‡	961	307	295	2,255	-	113	124	2,378
Statewide Total	**11,128**	**4,084**	**4,241**	**57,199**	**14.1**	**2,707**	**2,981**	**36,266**

* Cumulative HIV cases are those that have not progress to AIDS; pediatric HIV infections reported since 1994 and adult/adolescent HIV infections reported since 1999.

** Cumulative AIDS data includes all cases reported since 1980, including cases originally reported as HIV which have progressed to AIDS.

*** Rates represent cases per 100,000 population

‡ Texas Department of Criminal Justice

Texas HIV/STD: December 31, 2001

Chlamydia and Gonorrhea Cases, January – December 2001

Chlamydia and Gonorrhea: Residence Data				Jan - Dec 2001				
	Chlamydia				Gonorrhea			
Residence County	2001 Rate	2000 Total	Jan - Dec 2000	Jan - Dec 2001	2001 Rate	2000 Total	Jan - Dec 2000	Jan - Dec 2001
Region 1	*441*	*3,297*	*3,297*	*3,471*	*168*	*1,534*	*1,534*	*1,326*
Lubbock Co.	550	1,343	1,343	1,345	224	744	744	548
Potter/Randall Co.	456	962	962	1,006	215	480	480	473
Other	348	992	992	1,120	95	310	310	305
Region 2	*300*	*1,478*	*1,478*	*1,655*	*138*	*838*	*838*	*763*
Taylor Co.	494	478	478	629	145	227	227	185
Wichita Co.	340	500	500	450	260	434	434	344
Other	198	500	500	576	80	177	177	234
Region 3	*316*	*17,367*	*17,367*	*17,642*	*172*	*11,419*	*11,419*	*9,638*
Dallas Co.	455	9,979	9,979	10,254	274	7,317	7,317	6,175
Denton Co.	143	686	686	641	51	238	238	227
Tarrant Co.	284	4,215	4,215	4,161	156	2,785	2,785	2,293
Other	182	2,487	2,487	2,586	66	1,079	1,079	943
Region 4/5N	*309*	*3,694*	*3,694*	*4,261*	*171*	*1,924*	*1,924*	*2,359*
Angelina Co.	332	211	211	268	203	121	121	164
Bowie Co.	515	462	462	461	381	360	360	341
Gregg Co.	471	423	423	528	251	196	196	281
Smith Co.	429	707	707	755	280	408	408	493
Other	244	1,891	1,891	2,249	117	839	839	1,080
Region 6/5S	*301*	*16,629*	*16,629*	*16,026*	*142*	*8,356*	*8,356*	*7,562*
Galveston Co.	439	857	857	1,108	209	533	533	527
Harris Co.	325	12,218	12,218	11,233	159	5,917	5,917	5,486
Jefferson Co.	398	1,044	1,044	1,006	271	957	957	685
Montgomery Co.	132	380	380	398	45	155	155	135
Other	215	2,130	2,130	2,281	69	794	794	729
Region 7	*410*	*8,938*	*8,938*	*9,637*	*170*	*4,139*	*4,139*	*4,002*
Bell Co.	1,055	2,026	2,026	2,557	381	835	835	923
Brazos Co.	387	578	578	600	156	280	280	241
McLennan Co.	375	1,102	1,102	805	245	696	696	526
Travis Co.	408	3,120	3,120	3,379	190	1,531	1,531	1,574
Other	252	2,112	2,112	2,296	81	797	797	738
Region 8	*346*	*7,505*	*7,505*	*7,524*	*118*	*2,693*	*2,693*	*2,558*
Bexar Co.	410	5,880	5,880	5,777	152	2,301	2,301	2,146
Victoria Co.	563	418	418	478	168	85	85	143
Other	187	1,207	1,207	1,269	40	307	307	269
Region 9/10	*332*	*4,285*	*4,285*	*4,128*	*62*	*774*	*774*	*776*
El Paso Co.	341	2,226	2,226	2,354	42	209	209	292
Midland Co.	300	408	408	350	115	141	141	134
Other	326	1,651	1,651	1,424	80	424	424	350
Region 11	*315*	*5,565*	*5,565*	*5,590*	*64*	*1,218*	*1,218*	*1,132*
Cameron/Hidalgo Co.	283	2,648	2,648	2,626	25	220	220	231
Nueces Co.	460	1,523	1,523	1,460	210	774	774	667
Webb Co.	226	503	503	450	9	38	38	17
Other	318	891	891	1,054	66	186	186	217
Statewide Total	**333**	**68,758**	**68,758**	**69,934**	**142**	**32,895**	**32,895**	**30,116**

* Rates are cases per 100,000 population

Pelvic Inflammatory Disease and Chancroid, January – December 2001

Pelvic Inflammatory Disease and Chancroid: Residence Data											Jan - Dec 2001
	Pelvic Inflammatory Disease (PID)								Chancroid		
	Chlamydia		Gonorrhea		Other/Unspecified		Total PID				
Residence County	Jan - Dec 2000	Jan - Dec 2001	Jan - Dec 2000	Jan - Dec 2001	Jan - Dec 2000	Jan - Dec 2001	Jan - Dec 2000	Jan - Dec 2001	2000	Jan - Dec 2000	Jan - Dec 2001
Region 1	***32***	***43***	***20***	***23***	***22***	***20***	***74***	***86***	-	-	***1***
Lubbock Co.	2	3	2	1	3	5	7	9	-	-	-
Potter\Randall Co.	13	23	5	12	14	10	32	45	-	-	-
Other	17	17	13	10	5	5	35	32	-	-	1
Region 2	***35***	***15***	***22***	***10***	-	***2***	***57***	***27***	-	***1***	***3***
Taylor Co.	21	9	13	5	-	-	34	14	-	-	-
Wichita Co.	1	1	2	1	-	1	3	3	-	1	3
Other	13	5	7	4	-	1	20	10	-	-	-
Region 3	***138***	***302***	***110***	***136***	***517***	***364***	***765***	***802***	***8***	***11***	***1***
Dallas Co.	79	108	84	75	496	340	659	523	4	6	1
Denton Co.	3	23	-	8	-	2	3	33	1	-	-
Tarrant Co.	2	6	-	3	7	8	9	17	2	2	-
Other	54	165	26	50	14	14	94	229	1	3	-
Region 4/5N	***3***	***3***	***2***	***3***	***1***	***2***	***6***	***8***	-	-	-
Angelina Co.	-	0	1	-	-	-	1	-	-	-	-
Bowie Co.	-	1	-	-	-	-	-	1	-	-	-
Gregg Co.	-	1	-	-	-	-	-	1	-	-	-
Smith Co.	1	0	-	-	-	-	1	-	-	-	-
Other	2	1	1	3	1	2	4	6	-	-	-
Region 6/5S	***54***	***39***	***54***	***32***	***202***	***201***	***310***	***272***	***7***	***3***	***1***
Galveston Co.	18	13	23	14	-	1	41	28	-	-	-
Harris Co.	30	21	26	15	200	196	256	232	7	3	1
Jefferson Co.	-	1	-	1	-	-	-	2	-	-	-
Montgomery Co.	2	0	1	-	1	1	4	1	-	-	-
Other	4	4	4	2	1	3	9	9	-	-	-
Region 7	***59***	***55***	***42***	***24***	***3***	-	***104***	***79***	-	***1***	-
Bell Co.	8	5	3	1	-	-	11	6	-	-	-
Brazos Co.	1	1	1	1	-	-	2	2	-	-	-
Mclennan Co.	11	3	9	4	-	-	20	7	-	1	-
Travis Co.	22	22	23	13	-	-	45	35	-	-	-
Other	17	24	6	5	3	-	26	29	-	-	-
Region 8	***25***	***18***	***16***	***12***	***15***	***7***	***56***	***37***	-	***2***	-
Bexar Co.	16	9	14	6	11	4	41	19	-	1	-
Victoria Co.	1	3	-	1	1	-	2	4	-	-	-
Other	8	6	2	5	3	3	13	14	-	1	-
Region 9/10	***41***	***45***	***15***	***10***	***5***	***10***	***61***	***65***	-	***1***	-
El Paso Co.	4	1	3	4	-	-	7	5	-	1	-
Midland Co.	6	16	2	3	3	7	11	26	-	-	-
Other	31	28	10	3	2	3	43	34	-	-	-
Region 11	***288***	***233***	***37***	***47***	***41***	***22***	***366***	***302***	***1***	-	***1***
Cameron/Hidalgo Co.	108	66	1	2	22	4	131	72	-	-	1
Nueces Co.	100	111	28	40	13	3	141	154	1	-	-
Webb Co.	27	12	1	-	2	6	30	18	-	-	-
Other	53	44	7	5	4	9	64	58	-	-	-
Statewide Total	675	753	318	297	806	628	1,799	1,678	16	19	7

Syphilis Cases, January – December 2001

Syphilis: Residence Data													Jan - Dec 2001
	Congenital			Primary/Secondary				Early Latent			Total Syphilis		
Residence County	2000	Jan - Dec 2000	Jan - Dec 2001	Total 2000	Jan-Dec 2000	Jan - Dec 2001	2001 Rate	2000	Jan - Dec 2000	Jan - Dec 2001	2000	Jan - Dec 2000	Jan - Dec 2001
Region 1	***1***	***1***	-	***2***	***2***	***19***	***2.4***	***14***	***14***	***26***	***33***	***33***	***94***
Lubbock Co.	1	1	-	2	2	-	-	1	1	1	8	8	13
Potter\Randall Co.	-	-	-	-	0	16	7.3	4	4	14	6	6	37
Other	-	-	-	-	0	3	0.9	9	9	11	19	19	44
Region 2	-	-	***2***	***4***	***4***	***10***	***1.8***	***4***	***4***	***12***	***41***	***41***	***54***
Taylor Co.	-	-	-	1	1	-	-	1	1	1	2	2	3
Wichita Co.	-	-	2	3	3	9	6.8	3	3	7	15	15	27
Other	-	-	-	-	0	1	0.3	-	-	4	24	24	24
Region 3	***11***	***11***	***16***	***141***	***141***	***170***	***3.0***	***489***	***489***	***345***	***882***	***882***	***1,062***
Dallas Co.	7	7	7	100	100	123	5.5	361	361	246	588	588	704
Denton Co.	-	-	-	4	4	1	0.2	6	6	8	14	14	20
Tarrant Co.	4	4	8	22	22	40	2.7	80	80	62	192	192	273
Other	-	-	1	15	15	6	0.4	42	42	29	88	88	65
Region 4/5N	***5***	***5***	***9***	***19***	***19***	***11***	***0.8***	***111***	***111***	***90***	***193***	***193***	***188***
Angelina Co.	-	-	-	5	5	2	2.5	13	13	4	25	25	16
Bowie Co.	-	-	-	1	1	-	-	6	6	5	10	10	7
Gregg Co.	-	-	2	3	3	1	0.9	20	20	16	29	29	22
Smith Co.	-	-	1	2	2	1	0.6	22	22	19	27	27	27
Other	5	5	6	8	8	7	0.8	50	50	46	102	102	116
Region 6/5S	***33***	***33***	***20***	***115***	***115***	***126***	***2.4***	***302***	***302***	***259***	***1,160***	***1,160***	***1,194***
Galveston Co.	-	-	-	1	1	4	1.6	23	23	20	30	30	31
Harris Co.	29	29	20	70	70	101	2.9	135	135	137	849	849	929
Jefferson Co.	-	-	-	14	14	8	3.2	21	21	29	63	63	72
Montgomery Co.	3	3	-	1	1	-	-	10	10	1	19	19	6
Other	1	1	-	29	29	13	1.2	113	113	72	199	199	156
Region 7	-	-	***4***	***21***	***21***	***37***	***1.6***	***62***	***62***	***68***	***177***	***177***	***253***
Bell Co.	-	-	1	3	3	1	0.4	6	6	5	18	18	12
Brazos Co.	-	-	-	2	2	7	4.5	6	6	9	14	14	31
McLennan Co.	-	-	-	1	1	3	1.4	6	6	3	17	17	13
Travis Co.	-	-	2	8	8	17	2.1	27	27	32	59	59	116
Other	-	-	1	7	7	9	1.0	17	17	19	69	69	81
Region 8	***5***	***5***	***8***	***75***	***75***	***75***	***3.5***	***110***	***110***	***133***	***322***	***322***	***410***
Bexar Co.	4	4	8	67	67	71	5.0	103	103	123	286	286	369
Victoria Co.	-	-	-	3	3	2	2.4	3	3	4	10	10	15
Other	1	1	-	5	5	2	0.3	4	4	6	26	26	26
Region 9/10	***2***	***2***	***3***	***7***	***7***	***15***	***1.2***	***12***	***12***	***21***	***215***	***215***	***194***
El Paso Co.	2	2	2	6	6	12	1.7	11	11	15	92	92	106
Midland Co.	-	-	-	-	0	-	-	-	-	-	4	4	3
Other	-	-	1	1	1	3	0.7	1	1	6	119	119	85
Region 11	***14***	***14***	***10***	***14***	***14***	***16***	***0.9***	***71***	***71***	***18***	***280***	***280***	***251***
Cameron/Hidalgo Co.	11	11	6	11	11	12	1.3	51	51	12	170	170	139
Nueces Co.	-	-	-	1	1	1	0.3	3	3	1	10	10	9
Webb Co.	2	2	3	1	1	2	1.0	14	14	5	48	48	49
Other	1	1	1	1	1	1	0.3	3	3	-	52	52	54
Statewide Total	71	71	72	398	398	479	2.3	1,175	1,175	972	3,303	3,303	3,700

* Rates are reported as cases per 100,000 population

Texas Department of Health
Bureau of HIV and STD Prevention

Publication #13-10667

06/03